Implementing the Torture Convention

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Implementing the Torture Convention: protecting human dignity and integrity in healthcare

The functioning of the NPMs in the Netherlands with respect to persons deprived of their liberty residing in healthcare settings

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Preface

'Health care settings should be places where human rights are realized' (Open Society Foundations)

The global campaign 'Stop Torture in Health Care' of the Open Society Foundations aims to end violations of human rights and ill-treatment in health care settings. It aims to enhance the responsibility of governments for ill-treatment in care institutions. The present research has been conducted within the framework of this OSF campaign.

Under the Optional Protocol to the UN Convention against Torture (OPCAT) States parties are required to designate so-called National Preventive Mechanisms (NPMs) to monitor and conduct regular visits to places of detention and make recommendations to the authorities for improvements in the treatment of persons deprived of their liberty and their conditions of detention. The NPMs also focus on health care settings. This research focuses on the functioning of these mechanisms in the Netherlands with respect to health care settings.

This research could not have been carried out without the help of a number of organizations and persons. The researchers wish to thank these organizations and persons for their helpful support and advice. They are also very grateful to their advisors, Adriaan van Es and Professor Rachel Murray, for their time, efforts, and their useful advice, as well as Marie-Sophie Keller and Lottie Lane for the final editing of the report. We also wish to extend our thanks to the OSF for providing the funding to carry out this research, and to the Faculty of Law of the University of Groningen for facilitating it.

Summary

This report focuses on the following central question:

How do the Dutch NPMs carry out their supervisory role with respect to relevant health care institutions?

To address this question, we have scrutinized the functioning of the Dutch NPMs when carrying out visits to non-traditional places of detention. Based on a set of interviews with relevant stakeholders we conclude that although a very positive framework has been laid for the functioning of the designated NPMs, more efforts need to be made for the NPMs to come to a better exercise of their tasks. The designated NPMs have in principle the expertise and competences for what is required of an NPM; however they have not changed anything in their approach since their designation as an NPM. For instance, they do not carry out specific 'NPM visits', but rather consider that their regular inspection visits are sufficient to qualify as an NPM. This may denote a lack of awareness of the fact that NPMs under the OPCAT become part of an international framework of preventive bodies. This carries an expectation to exercise their mandate in accordance to what is expected from them in the OPCAT and in close cooperation with the UN Subcommittee on the Prevention of Torture (SPT), the international visiting body established by the Protocol.

Our recommendations are as follows:

- The Government of the Netherlands and in particular the Ministry of Justice and Security of the Netherlands should create clarity regarding the question of whether in the Netherlands there is one NPM or whether there are several NPMs.
- The Government of the Netherlands should lay down the mandate and competences of the NPMs in legislation, in conformity with the SPT guidelines, so as to enhance the presumed independence of the NPMs.
- The Government should also ensure that there is sufficient budget for the NPMs. In turn, the NPMs can ask for the support of SPT when it comes to addressing the Dutch government's obligations in this regard.
- The Government and other stakeholders should create more awareness about the international standards both for the Dutch NPMs and with society at large.
- Organizations designated as NPMs increase the awareness of forming part of an international framework to prevent torture and IDT, in particular in health care settings, within their own organizational structures and to the relevant stakeholders and partners in the health care sector; additionally they should mention information about their qualification as an NPM on their website and on their annual reports in so far this has not yet been done.
- The Government of the Netherlands should create clarity concerning the applicability of OPCAT on the BES-islands.
- The Netherlands (i.e. the relevant stakeholders: the Dutch Government, House of Representatives, the NPMs and associates as well as civil society organizations) should evaluate the functioning of the NPMs after two years.

1. Background and project goals

1.1 Rationale and project goals

The Optional Protocol to the Convention against Torture (OPCAT) entered into force in June 2006. According to Article 3 OPCAT, one year after ratification States Parties have to establish one or more independent national preventive mechanisms (NPMs) that will conduct visits to closed settings (see also OSF's manual).[1] With the establishment of the NPMs the OPCAT has introduced an innovative method of monitoring the implementation of human rights obligations, as it mandates monitoring from within the State, something that hitherto was unthinkable under international law. Under the OPCAT States Parties have considerable leeway to maintain, designate or establish a body, or group or bodies, which fits their particular national context and needs. In practice, States Parties either designate a single or

[1] OSF, *Twenty mechanisms for addressing torture in healthcare*, p. 58. Available at: http://www.soros.org/publications/twenty-mechanisms-addressing-torture-health-care, last visited 28 August 2012.

several existing bodies, or they create new institutions to fulfill the role of NPM.[2] However, the flexibility of States in deciding which body can operate as an NMP also has certain limits, including that the NMP must be allowed to visit any place of detention under the State Party's jurisdiction.[3] This implies that NPMs must be in a position to visit both traditional and less traditional places of detention.[4] As a result, such visits may also concern (private) hospitals, psychiatric and other health care institutions, and facilities in which persons are deprived of their liberty. As a result, NPMs may also visit a wide range of health care institutions and pay attention of the issue of 'torture in healthcare settings'.

The Netherlands ratified the OPCAT on 28 September 2010. It subsequently designated six existing national inspectorate bodies, including a body on youth care and a body on health care, which are coordinated by the Inspectorate for Security and Justice (IVeJ, formerly the Inspectorate for Implementation of Sanctions) as the official NPMs (see also the box in section 3.1).[5] Given the recent designation of these bodies, little information has been made available publicly on the functioning of these bodies in light of their duties under OPCAT. Nevertheless, a number of these visiting bodies already have considerable experience in the exercise of their inspecting mandate. Whether these bodies in their setup and in their visits amount to what is expected of NPMs under the OPCAT, however, remains to be seen. In practice, existing bodies that have been designated as NPMs to fulfill a particular State Party's obligations under the OPCAT could carry out their activities as though nothing has institutionally changed with a 'business as usual' attitude.[6] What these bodies do not themselves realize, however, is that through the ratification or accession to the OPCAT by their country, they have become an additional cog in what amounts to an international integrated machinery to prevent torture,[7] with certain responsibilities under the OPCAT.[8] It is necessary to research whether the designated bodies in the Netherlands meet the expectations imposed upon them by the OPCAT.

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[2] Antenor Hallo de Wolf, *Visits to Less Traditional Places of Detention: Challenges under the OPCAT*, Essex Human Rights Review, Vol. 6, Nr. 1 (2009), p. 79.

[3] Article 4(1) OPCAT. See Hallo de Wolf, p. 80.

[4] See also Article 4(2) OPCAT.

[5] Available at: http://www2.ohchr.org/english/bodies/cat/opcat/mechanisms.htm , last visited 15 July 2013.

[6] See R. Murray, E. Steinerte, M. Evans and A. Hallo de Wolf, *The Optional Protocol to the UN Convention Against Torture*, Oxford University Press, Oxford (2011), p. 118-119.

[7] Through the combination of Articles 11(b)(ii), 12(c), and 20(d) of the OPCAT, a clear network to prevent torture and other types of cruel, inhuman or degrading treatment or punishment has been established with the UN Sub-committee on the Prevention of Torture (SPT) at its head, which should provide advice and assistance to the NPMs. At the other end of the spectrum NPMs have a right to have contacts with the SPT, and the States Parties have an obligation to encourage and facilitate these contacts.

[8] Murray, et al., p. 124.

Meanwhile in the Netherlands there have been several reports on abuse in health care settings. For example, there have been increasing reports on abuse in geriatric care.[9] A debate has been held in the Dutch House of Representatives (Tweede Kamer) about these incidents, and the role of the inspecting body, the Healthcare Inspectorate (Inspectie voor de Gezondheidszorg, IGZ) - one of the designated NPMs - has been criticized.[10] Other pressing issues concern the abuse of psychiatric patients and abuses in youth care.

Against the background of the abuses in the Dutch health care system, particularly in psycho-geriatric health care institutions, this project will look into the functioning of the recently established NPMs. Questions that will be addressed are:

- Which NPMs have been established in the Netherlands and what is their mandate?
- Does the mandate of the NPMs reflect OPCAT requirements?
- Which health care settings are covered, and which settings are left uncovered?
- How have the NPMs functioned so far?
- Which health care and legal standards aimed at preventing torture do they apply?
- Have they revealed important shortcomings of existing health care settings?
- In light of existing research on abuse in health care settings in the Netherlands, have they adequately covered these matters?
- What have they done with their findings?
- What can be done to improve the overall functioning of these bodies?

1.2 Research methodology

This research has been carried out between January and August 2013. The report is based on both legal and empirical research. For the legal dimension of the research use has been made of various international and national sources, including scholarly literature, treaty law, domestic legislation and regulation, policy documents and statements, annual reports and SPT reports, advisory reports and other publications of the Association for the Prevention of Torture (APT), the NPM annual report of 2011, as well as various inspection reports.

For the empirical dimension of the report, various semi-structured interviews have been carried out with the organizations in the Netherlands that have been designated as NPMs, as well as with the National Ombudsman (a so-called additional associate (toehoorder) of the NPM in the Netherlands), the Netherlands Institute for Human Rights, Pharos, Beweging 3.0, the chairperson of the SPT as well as two other SPT members and an APT employee.

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[9] *Inter* alia, Movisie, *Meer meldingen oudermishandeling*, [More reports on ill-treatment of the eldery]. Available at: http://www.movisie.nl/139792/def/home/nieuws/nieuws/persbericht_meer_meldingen_ouderenmishandeling/ , last visited 28 August 2012.

[10] See debate on the topic of abuse of geriatric patients in Handelingen Tweede Kamer TK 2011-2012, 96, 96-10-45 (14 June 2012) available at https://zoek.officielebekendmakingen.nl/h-tk-20112012-96-10.html, last visited 28 August 2012.

The interviews have been recorded in reports that have subsequently been submitted to the interviewees.[11] A draft of the final report has also been submitted to the interviewees. Annex 1 contains an overview of all the interviewees.

The report reflects a considerable number of comments and observations of the interviewees. We have attempted to structure the disjointed comments as much as possible, whilst respecting the nature of their comments. While some comments remain somewhat disjointed, we still consider them important to mention in this report. We apologize for any misrepresentation of comments made during the interviews.

1.3 How to read this report

Chapter 1 describes the rationale, aims and scope of the report as well as the research method. Chapter 2 provides a short background to OPCAT, the mandate of SPT and the OPCAT requirements for an NPM. Chapter 3 briefly addresses the issue of torture and IDT in health care settings. Chapter 4 gives an overview of the NPM system in the Netherlands. Chapter 5 provides an inventory of the risk factors for torture and inhuman or degrading treatment or punishment (hereinafter referred to as 'ill-treatment' or IDT) of persons deprived of their liberty in health care settings. Attention is also paid to the risk factors concerning the health of persons in detention. Chapter 6 presents the research findings; an assessment is made of whether the Dutch NPMs comply with the OPCAT criteria. In addition, based on the research findings, an overview is provided of the functioning of the NPMs with respect to the prevention of torture and ill-treatment of persons deprived of their liberty in health care settings in the Netherlands. Chapter 7 contains the conclusions to the research.

2 OPCAT

2.1 Short background history

International law recognizes torture and other types of inhuman or degrading treatment or punishment as one of the most heinous acts that a person can commit against another person. Various international and regional human rights instruments adopted after World War II have aimed to eliminate the practice of torture.[12] The international community's efforts have been mainly geared towards prohibiting and criminalizing the practice of torture and IDT. This has been encapsulated, for example, in Article 4 of the CAT. However, there is a growing realization that preventing these terrible acts from taking place is perhaps a more sensible approach. The OPCAT's historical roots can be traced back to the ideas and initiatives proposed by Jean-Jacques Gautier, a Swiss jurist and banker and founder of the Association for the Prevention of Torture (APT). Gautier was inspired by the International Committee of the Red Cross' activities as a visiting body of places of detention in times of armed conflict. He considered that such an approach would be valuable as a means to prevent torture in

[11] With the exception of the interviewees from SPT and APT.

[12] See for example Article 5 of the Universal Declaration of Human Rights, Article 7 of the International Covenant on Civil and Political Rights, Article 5 of the American Convention on Human Rights, Article 5 of the African Charter on Human and Peoples' Rights, and Article 3 of the European Convention on Human Rights.

places where persons are the most vulnerable to such acts, namely in places where persons are deprived of their liberty and are at the mercy of the conduct of public officials.

The idea to prevent torture and IDT was also embraced in Article 2 (1) of the CAT as a legal obligation.[13] The CAT was adopted in 1984, and although discussions were held during its drafting based on Gautier's ideas on the establishment of a mechanism that would help States Parties to comply with the legal obligation to prevent torture, this issue was deemed to be too complicated and controversial and was abandoned.[14] The practical and functional implementation of the legal obligation to prevent torture and IDT was left to individual member states. Nonetheless, Gautier's ideas later found acceptance when the Council of Europe adopted the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. This European Convention established an independent visiting body, the European Committee for the Prevention of Torture (ECPT), with a mandate to visit places in which persons are deprived of their liberty. The success of this system led to a reassessment of the desirability of introducing a similar system at the international level. Thus, the way was paved for the drafting the OPCAT, which, after a protracted drafting process, was adopted in 2002 and entered into force in June 2006.[15]

2.2 Aim and scope of OPCAT

The Protocol's purpose is to establish a mechanism to assist States in fulfilling their obligation to prevent torture and other forms of ill-treatment, as laid down in Article 2(1) of the CAT.[16] According to Article 2.1, each State Party shall take effective legislative, administrative, judicial and other measures to prevent acts of torture in any territory under its jurisdiction", while Article 16 requires that "each State Party shall undertake to prevent (…) other acts of cruel, inhuman or degrading treatment or punishment." The aim of the OPCAT is "to establish a system of regular visits undertaken by independent international and national bodies to places where people are deprived of their liberty", in order to prevent torture or ill-treatment.

The OPCAT has a two-pronged approach to prevent torture through pro-active visits to places in which persons are deprived of their liberty: States Parties to the OPCAT are obliged to allow visits by an international body, the UN Subcommittee on the Prevention of torture and other cruel, inhuman or degrading treatment or punishment (SPT), to any place under their jurisdiction and control where persons are, or may be deprived of their liberty.

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[13] Article 2(1) of the CAT states that "[e]ach State Party shall take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction." Article 16 (1) of the CAT imposes a similar obligation with respect to IDT.

[14] See M.D. Evans and C. Haenni-Dale, 'Preventing Torture? The Development of the Optional Protocol to the UN Convention Against Torture,' *Human Rights Law Review*, Vol. 4 (2004), p. 19 – 55, at p. 24.

[15] For a detailed discussion of the protracted drafting process of the OPCAT see M.D. Evans and C. Haenni-Dale, 'Preventing Torture? The Development of the Optional Protocol to the UN Convention Against Torture.'

[16] Report of the Working Group on the Draft Optional Protocol to the Convention against Torture and Other Cruel, or Degrading Treatment or Punishment, Commission on Human Rights, UN Doc. E/CN.4 /1993/28 (1992), para. 30.

Secondly, States Parties are also under the obligation to establish, designate, or maintain independent national bodies (National Prevention Mechanisms or NPMs) with a similar mandate to visit places of detention. OPCAT's mandatory establishment of NPMs as a method of monitoring the implementation of human rights obligations is innovative: it mandates monitoring from within the States, which is a novelty under international law.[17]

The OPCAT does not provide a definition of torture or IDT. This can be found in Articles 1 and 16 of the CAT respectively. With respect to torture, Article 1 provides a number of elements that qualify a particular act as one involving torture:

- an act that inflicts severe mental or physical pain,
- the intent to inflict such a pain
- a particular purpose
- a connection with an official authority

IDT constitutes acts that do not amount to torture. Their qualification as such will depend on various aspects, such as the amount of pain or suffering inflicted. The main difference with torture will usually entail the purpose and intention behind the act in question.[18] The OPCAT aims at preventing both types of acts.

As already stated, the OPCAT allows the SPT and the NPMs to carry out visits to places of detention with the aim of preventing torture and IDT. The approach to places of detention adopted by the OPCAT is broad.[19] The Protocol does not provide a list of places that should be subject to visits, but refers only to 'any place where persons are or may be deprived of their liberty'. This will usually include traditional places of detention such as prisons and police cells. Article 4(2) expands the coverage of the OPCAT to places that persons are not permitted to leave at will, including private places of detention. This means that not only privatized prisons, but also private hospitals, psychiatric and other institutions, facilities, or establishments in which persons are held against their will on the basis of public order, or at the instigation or with the acquiescence of a public authority, fall under the scope of OPCAT. The key criteria for considering whether or not a particular place can be regarded a place of detention that needs to be visited are (i) whether the place falls under the jurisdiction and control of the State Party; (ii) whether the place deprives them of their liberty; and (iii) whether the deprivation of liberty is linked to a decision, act, or the conduct of a public authority.

2.3 SPT: mandate

[17] Hallo de Wolf, pp. 79.

[18] For a discussion about the definition of torture see M. Evans, 'Getting to Grips with Torture, *ICLQ* Vol. 51 (2002), p. 365 – 383.

[19] Evans and Haenni-Dale, 'Preventing Torture?', p. 43-44.

The SPT observed that the Subcommittee, 'is a new type of United Nations treaty body with a unique mandate'.[20] Unlike the UN Special Rapporteur on Torture, or the UN Working Group on Arbitrary Detention, the SPT is entitled to visit countries that have ratified the OPCAT without previously requesting permission to do so.[21] The SPT has two main functions: in the first place, it visits places of deprivation of liberty to examine current practice and system features in order to identify where the gaps in the protection exist and which safeguards require strengthening; in the second place, it assists "in the development and functioning of bodies designated by States Parties to carry out regular visits- the NPMs. The SPT focus is empirical- on what actually happens and what practical improvements are needed to prevent ill-treatment."[22]

The mandate of the SPT can be found in Article 11 of the OPCAT:

- visit places of deprivation of liberty in the states parties to the OPCAT and make recommendations to the respective authorities with the aim of improving the prevention of torture and inhuman treatment;
- assist and advise States Parties in setting up their own NPMs,[23] and to assist these NPMs in their work;
- cooperate with other relevant UN organs and mechanisms as well as other international, regional and national institutions or organizations working towards the strengthening of the protection of all persons against torture and other forms of ill-treatment.

The visiting component of the SPT's mandate comprises of sending a delegation to visit places of deprivation of liberty. During its visits, the Subcommittee examines conditions of detention, legislative and institutional frameworks, and other areas that may be related to the prevention of torture and IDT. At the end of its country visits, it communicates its recommendations and observations to the State by means of a confidential report, and if necessary, to the NPMs. However, States Parties are encouraged to request the SPT to publish the visit report.[24]

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[20] SPT, First Annual Report, UN Doc. CAT/C/42/2 (2009), para 13.

[21] Hallo de Wolf, p. 77.

[22] Subcommittee on Prevention of Torture, 'Report on the visit of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment to Sweden', UN Doc. CAT/OP/SWE/1, 10 September 2008, p. 3.

[23] To this end the SPT has adopted a number of guidelines "to add further clarity regarding the expectations of the SPT regarding the establishment and operation of NPMs." See Guidelines on National Preventive Mechanisms (SPT Guidelines), Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, UN Doc. CAT/OP/12/5, 9 December 2010, para. 3.

[24] At the moment 7 of the 17 officially visited countries have given the SPT their consent to make the visit reports public. See: http://www2.ohchr.org/english/bodies/cat/opcat/spt_visits.htm (last visited 29 July 2013).

The SPT's activities are guided by the principles of confidentiality, impartiality, non-selectivity, universality and objectivity. This places cooperation as a top priority of the SPT's activities, and it will seek to engage the States Parties through constructive dialogue and collaboration. The SPT's mandate is not geared towards condemnation. The SPT is not, however, altogether toothless. The Committee against Torture, at the request of the SPT, can make a public statement or publish the SPT report of States that refuse to cooperate or which fail to adopt measures to improve the situation, as recommended by the SPT.[25]

2.4 NPMs: important features and mandate

By introducing a national component in the form of the NPMs, the OPCAT made an innovative contribution to the fight against torture under international (human rights) law: the notion of a mandatory visiting body to complement the visits carried out by an international body. The OPCAT is very flexible with regard to the choice of mechanisms to fulfill the role of NPM. Under Article 3, States Parties must 'set up, designate, or maintain at domestic level one or several visiting bodies for the prevention of torture'. This provides States Parties to the OPCAT with ample room to set up a body, or group of bodies, that fits their particular national context and needs. There are some limitations to this flexibility, however. In the first place, the NPM must be allowed to visit any place of detention under the State Party's jurisdiction or control where persons are being deprived of their liberty (OPCAT, Article 4). NPMs must, therefore, be in a position to visit both traditional and less traditional places of detention.

In the second place, under Article 18 of the OPCAT States are obliged to guarantee the functional independence of the NPM, as well as the independence of its personnel. For this purpose, the OPCAT requires States to give due consideration to the Principles relating to the status of national institutions for the promotion and protection of human rights (the 'Paris Principles')[34] when establishing or designating their NPM(s) (OPCAT, Article 18(4)). States are under an obligation to provide NPMs with the necessary facilities, guarantees, and resources to ensure that personnel are appointed in an appropriate way.[35]

In the third place, Article 19 and 20 of the OPCAT highlight a number of powers that NPMs should be granted for them to be able to perform their visiting function.[36]

Visiting Powers and Mandate

Articles 19-21 of the OPCAT set out minimal powers for NPMs. According to Article 19, an NPM has the power to:

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[25] See Art. 16(4) OPCAT. http://www2.ohchr.org/english/bodies/cat/opcat/index.htm. Last accessed 19 March 2013.

[34] Principles relating to the status of national institutions for the promotion and protection of human rights (Paris Principles), General Assembly resolution UN Doc. A/RES/48/134, 20 December 1993.

[35] Paris Principles, Composition and guarantees of independence and pluralism, para. 1.

[36] Hallo de Wolf, p. 79-80.

- regularly examine the treatment of the persons in detention, with a view to strengthening, if necessary, their protection against torture and other cruel, inhuman or degrading treatment or punishment;
- make recommendations to the relevant authorities with the aim of improving the treatment and the conditions of the persons deprived of their liberty;
- submit proposals and observations concerning existing or draft legislation.

To enable NPMs to exercise these powers, they should have:[37]

- access to all information concerning the number of people deprived of their liberty, as well as the number of places of detention and their location;
- access to all information referring to the treatment of those persons as well as their conditions of detention;
- access to all places of detention and their installations and facilities;
- the opportunity to have private interviews with the persons deprived of their liberty without witnesses, either personally or with a translator if deemed necessary, as well as with any other person whom the national preventive mechanism believes may supply relevant information;
- the liberty to choose the places they want to visit and the persons they want to interview;
- the right to have contacts with the SPT, to send information and to meet with it.

Article 21 provides for protection for those who communicate with the NPM and for confidential information collected by it to be privileged. Articles 22 and 23 require the State authorities to examine the recommendations of the NPM and enter into a dialogue with it and also to publish and disseminate the annual report of the NPM.

Independence

Article 18(1) and the SPT Guidelines stress the 'operational independence' and 'complete financial and operational autonomy' of the NPM.[38] Murray *et al* distinguish those factors that are within the control of the State from those within the control of the NPM itself.[39]

Factors within the control of the State

(a) Appointment of members of the framework.

[37] OPCAT, Article 20.

[38] SPT Guidelines, paras 8 and 12.

[39] Murray e.a., p. 120.

The manner of appointment of NPM members is of great importance. Consideration should be given to the way in which existing bodies appoint their staff members, given that this may have an impact on the legitimacy of the body when it exercises its OPCAT functions.

(b) Financial autonomy

According to the Paris Principles, the institution should have the power to investigate, report, manage its own budget, and appoint its own staff.[40] Funding includes not only the need for sufficient resources to enable it to carry out its mandate, but also that it should be free to make decisions on how best to allocate funding for specific aspects of its work.[41]

Factors within the control of the OPCAT itself

(a) Fulfilling its remit

An NPM is not responsible for the conditions under which it is established and the manner of the appointment of its members, for example, but it should be accountable for performing its mandate, 'conscientiously and competently' and for how it spends its money.[42] An NPM must also decide how best to spend its resources and allocate its budget. The Guidelines of the SPT call on NPMs to 'regularly review their working methods and undertake training' and 'establish a work plan/programme'. [43]

(b) Engaging with others

Independence means that there has to be distance between the NPM to the controlled institutions in the first place. The NPM also has to engage in a constructive dialogue with the authorities.[44] The NPM cannot be seen to operate in isolation, and an effective NPM is one which has close cooperation with and involvement of civil society. According to Murray *et al*,, the NPM could become the center of a national torture prevention network.[45] However, independence has to be established also with respect to other stakeholders such as national parliamentary bodies or even civil society.[46] Thus, in the opinion of Steinerte *et al*.

> "[i]t is often the perception of independence that is more important than whether, for example, the members of the institution have been appointed by the executive or not. Independence is therefore a subtle and nuanced concept that cannot be captured by a

[40] Paris Principles, Composition and guarantees of independence and pluralism, para. 2.

[41] Murray e.a., p. 123.

[42] Murray e.a., p. 124.

[43] SPT, Guidelines on NPMs, paras. 31 and 33.

[44] Murray e.a. p. 125.

[45] Ibid., p. 126.

[46] Ibid. See also Elina Steinerte, Rachel Murray & Judy Laing, ´Monitoring those deprived of their liberty in psychiatric and social care insitutiions and national practice in the UK´, *The International Journal of Human Rights*, Vol. 16, No. 6, August 2012, p. 865 – 882 at p. 875.

simple application of the Paris Principles or the text of OPCAT and the Convention on the Rights of Persons with Disabilities. It requires the national visiting body to maintain a close but influential relationship with the State authorities but at the same time to be able to operate at a distance from it. It needs to engage with a variety of different stakeholders but to be prepared to critique them as and when necessary."[47]

(c) Integrity of institution's members

How effective the NPM is and how well it is perceived will depend largely on the integrity of the individuals who sit on or work within the particular institution.[48]

According to Murray e.a.,

> "Independence also means the ability to operate without influence, not just from government but also from others. An NPM which is seen as being too easily influenced by NGOs and civil society may find it difficult to gain the ear of government[.]"[49]

Expertise

According to the SPT's Guidelines, "[t]he NPM should ensure that its staff have between them diversity of background, capabilities and professional knowledge necessary to enable it to properly fulfill its NPM mandate. This should include**,** *inter alia*, relevant legal and health care expertise."[50]

Some member States have chosen to create a new body as NPM. Others (f.e. Sweden, New Zealand, UK,The Netherlands) have chosen to designate an existing body or a number of existing bodies as NPM. Building on the expertise and reputation of an existing institution could be advantageous. However, some existing institutions have characteristics that do not always seem to be compatible with the requirements of an inspection body or a preventive mechanism. In a constellation of various existing bodies, there is not only a need for synergy between the international and national level, but also amongst the various national actors.[51]

Visit methodology

[47] Ibid.

[48] SPT, Guidelines on NPMs, para 30.

[49] Murray e.a., p. 128.

[50] SPT Guidelines, para 20.

[51] International conference. The triangular relationship between SPT, CPT and NPM: inspection in the field of detention on a global, regional and domestic level, organized by Inspectorate of Security and Justice and VU University of Amsterdam, 1st of June 2012.

The NPM should develop guidelines for visits to the various categories of places of detention, including guidelines for conducting private interviews, policies for dealing with vulnerable groups of inmates, and ensuring that information from all available sources is collected.[52]

According to the SPT, "[v]isit reports should focus on the most important issues, i.e. reporting ill-treatment, gaps in policies, regulations, and practiced, as well as the appropriateness of conditions under which inmates are living, reflecting the systematic lack of protection of the rights of inmates."[53]

Regularity of visits

Article 1 of OPCAT requires that visits carried out by NPMs and the SPT be regular, without any specification as to what this means. The question is how frequent the visits need to be to reach the requisite standards of regularity envisaged in OPCAT. There appears to be no agreed international standard on the matter. Steinerte *et al.* observe that, "[n]either the SPT nor the ECPT, for example, have specified the requisite level of frequency, and thus the discrepancy between the understanding of what constitutes 'regular' visits among national visiting bodies remains."[54]. The ATP appears to be in favor of longer in-depth visits, which would last three to four days, mixed with shorter *ad hoc* visits.[55] In-depth visits to police stations and other places that may contain a large amount of vulnerable groups as well as places with consistent problems should, according to the APT, be visited at least once a year, whereas others could suffice with in-depth visits once every three years.[56]

Annual report

The SPT recommends that the annual report of the NPM includes:

- Accounts of current challenges to the protection of the rights of persons deprived of their liberty and to the effective execution of the NPM's mandate, and strategic short and longer term plans, including setting priorities;
- Analysis of the most important findings and an account of recommendations and the responses of the authorities to them;
- Follow-up on issues outstanding from previously published reports;
- Consideration of thematic issues;
- Accounts of cooperation with other actors on the prevention of torture.[58]

[52] SPT Analytical self-assessment tool for National Preventive Mechanisms, UN Doc CAT/OP/1 (2012), p. 5.

[53] Ibid.

[54] Steinerte, e.a. (2012), p. 870

[55] APT, *Establishment and Designation of National Preventive Mechanisms* (Geneva: APT, 2006), p. 36.

[56] Ibid., Steinerte, e.a. (2012), p. 870.

[58] SPT Analytical self-assessment tool for National Preventive Mechanisms, UN Doc CAT/OP/1 (2012), para. 38.

Development of NPMs

According to the SPT's tool for the analytical self-assessment of NPMs, "[t]he development of national preventive mechanisms should be considered an ongoing obligation, with reinforcement of formal aspects and working methods refined and improved incrementally."[59] After their establishment, the NPMs and the SPT are supposed to maintain direct contact, and the latter should offer the former training and technical assistance with the aim of strengthening the NPMs' capacities. The NPMs are expected to find and indicate creative solutions to challenges it may face; for example reluctance within bureaucracies to change existing practices, lack of resources to implement their mandates and recommendations, or even negative public opinion.[60] The SPT suggests seeking partnerhsips with other relevant actors at the national and international levels "[…] in order to raise awareness of the obligations of the State Parties among decision-makers and within the general public in order to encourage and facilitate change in legislation, policies of authorities, general attitudes, and conditions and practices in places of detention."[61] The SPT further suggests that NPMs should develop strategies and continuously monitor and analyze their own activities to draw lessons that can be applied to improve on their practices. This is relevant to secure the effectiveness of their main activities: visiting institutions and assessment of legislation related to NPMs' mandate. Ongoing training of members of staff of the NPMs is also crucial.[62]

According to the SPT, key features of NPMs are[63]:

(a) The mandate and powers of the NPM should be clearly and specifically established in national legislation as a constitutional or legislative text. The broad definition of places of deprivation of liberty as per OPCAT shall be reflected in that text;

(b) The NPM should be developed by a public, inclusive and transparent process of establishment, including civil society and other actors involved in the prevention of torture; where an existing body is considered for designation as the NPM, the matter should be open for debate, involving civil society;

(c) The independence of the NPM, both actual and perceived, should be fostered by a transparent process of selection and appointment of members who are independent and do not hold a position which could raise questions of conflict of interest;

(d) Selection of members should be based on stated criteria relating to the experience and expertise required to carry out NPM work effectively and impartially;

(e) NPM membership should be gender balanced and have adequate representation of ethnic, minority and indigenous groups;

[59] Ibid., para. 3.

[60] Ibid., para. 4.

[61] Ibid., para. 4.

[62] Ibid., paras. 5 – 7..

[63] Report on the visit of the SPT to Sweden, UN Doc. CAT/OP/SWE/1 1 September 2008.

(f) The State shall take the necessary measures to ensure that the expert members of the NPM have the required capabilities and professional knowledge. Training should be provided to NPMs;

(g) Adequate resources should be provided for the specific work of NPMs in accordance with Article 18, 3 of the OPCAT; these should be ring-fenced, in terms of both budget and human resources;

(h) The work programme of NPMs should cover all potential and actual places of deprivation of liberty;

(i) The periodicity of NPM visits should ensure effective monitoring of such places as regards safeguards against ill-treatment;

(j) Working methods of NPMs should be developed and reviewed with a view to effective identification of good practice and gaps in protection;

(k) States should encourage NPMs to report on visits with feedback on good practice and gaps in protection to the institutions concerned, as well as with recommendations to the responsible authorities on improvements in practice, policy and law;

(l) NPMs and the authorities should establish an on-going dialogue based on the recommendations for changes arising from the visits and the action taken to respond to such recommendations, in accordance with Article 22 of the OPCAT;

(m) The annual report of NPMs shall be published in accordance with Article 23 of the OPCAT;

(n) The development of NPMs should be considered an on-going obligation, with reinforcement of formal aspects and working methods refined and improved incrementally.

Visits to less traditional places of detention

There are several challenges with regard to less traditional paces of detention. These challenges relate to the presence of suitable expertise in the OPCAT visiting bodies for undertaking effective and meaningful visits to less traditional detention places, accessing those places, and making relevant recommendations, as well as coordinating visiting bodies. One of the main challenges facing the OPCAT's visiting bodies while visiting non-traditional places of detention is the need to guarantee that NPMs have sufficient expertise to allow them to take into account the specific settings, context, and nuances of less traditional places of detention.[64]

Further challenges, which apply equally to visits to traditional and less traditional places of detention, but which may have a larger impact on the latter, are (i) the necessity of ensuring (unrestricted) access to these places on a regular basis in all the territory/territories and jurisdiction(s) of the State, and (ii) guaranteeing that the recommendations issued by the visiting OPCAT body are relevant to the nature of the place or institution visited and are

[64] Hallo de Wolf, p. 88.

sufficiently detailed.[65] This is also related to the standards to be applied for the visits. According to Hallo de Wolf, "The standards to be applied, and the recommendations resulting from an OPCAT body visit to a less traditional place of detention, also need to be relevant to the place at issue."[66] In this regard, Steinerte *et al*. observe that the "[l]ack of clearly articulated substantive standards on psychiatric institutions and social care homes, which stands in stark contrast to the vast number of detailed instruments dealing with the institutions of the criminal system, like the Standard Minimum Rules for the Treatment of Prisoners, poses a difficult task for monitors of these institutions."[68]

3. Torture and IDT in health care settings

Under international law, any infliction of severe pain and suffering by a State actor or with State instigation, consent, or acquiescence can, depending on the circumstances, constitute either torture or ill-treatment. As observed above, Article 1, paragraph 1, of the UNCAT contains at least four essential elements in the definition of torture: an act inflicting severe pain or suffering, whether physical or mental; the element of intent the specific purpose; and the involvement of a State official, at least by acquiescence.

According to the SPT the term 'ill-treatment' should be interpreted in its widest sense, to include *inter alia* ill-treatment arising from inadequate material conditions of deprivation of liberty.[71]

The legal definition of torture and ill-treatment (see above) is broad enough to encompass a range of abuses occurring in health settings.[72] Whether an act qualifies as 'torture,' 'cruel and inhuman treatment or punishment,' or 'degrading treatment or punishment' depends on several factors, including the pain or suffering inflicted, the type of pain and suffering inflicted (i.e. physical or mental), whether the pain and suffering was inflicted intentionally and for an improper purpose, and whether the pain and suffering is incidental to lawful sanctions. Generally speaking, cruel and inhuman treatment or punishment can be intentional or unintentional and with or without a specific purpose, while torture is always intentional and with a specific purpose.[73] Documented examples of torture and IDT against specific populations in health settings are:

[65] Ibid., para. 93.

[66] Ibid., para. 95.

[68] Steinerte, e.a. (2012), p. 878.

[71] Report on the visit of the SPT to Sweden, UN Doc. CAT/OP/SWE/1 1 September 2008.

[72] Government Accountability for Torture and Ill-Treatment in Health Settings. An Open Society Foundations Briefing Paper, p. 1.

[73] Ibid., p. 1.

- People needing pain relief, whether as a part of palliative care or for chronic disease, injury, surgery, or labor may experience ill-treatment if their pain is severe enough and avoidable.

According to a report by Interights, "[p]eople with disabilities are especially vulnerable to torture and ill-treatment in health settings, though this is not the only context where they suffer such abuse."[74] For example, the "[u]se of caged beds in mental health facilities is a still-documented practice that violates the right to be free from torture and ill-treatment."[75]

UN Special Rapporteur on Torture, Mr. Juan Méndez states in his report that certain acts under national health care systems may violate the CAT. Méndez recognized that the report may arguably extend beyond his mandate as traditionally defined and into the realm of the "right to health", but explained that:

> "[t]here is a need to highlight the specific dimension and intensity of the problem, which often goes undetected; identify abuses that exceed the scope of violations of the right to health and could amount to torture and ill-treatment; and strengthen accountability and redress mechanisms."

The report provides examples of abuses that, according to the Special Rapporteur, may constitute torture or ill-treatment. Based on this review and an 'evolving' definition of torture, Special Rapporteur Méndez concluded that torture or ill-treatment in any facility that is meant to provide health care or medical treatment -whether private or public- can be considered a violation of the Convention.[76] In a statement given at the presentation of his report, the Rapporteur mentioned that "[m]edical care that causes severe suffering for no justifiable reason can be considered cruel, inhuman or degrading treatment or punishment, and if there is State involvement and specific intent, it is torture."[77]

Lack of access to palliative medication can violate the Convention against Torture. The Special Rapporteur has recognized that there are several obstacles that stand in the way of patients' access to these medications. These include "[o]verly restrictive drug control regulations and, more frequently, misinterpretation of otherwise appropriate regulations; deficiency in drug supply management; inadequate infrastructure; lack of prioritization of palliative care,"[78] among others. Although the Rapporteur acknowledged that while not every individual suffering without pain relief is the victim of torture he observed that, when the

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[74] Torture and Ill-Treatment in Health Settings: A Failure of Accountability - Campaign to Stop Torture in Health Care, Interights Bulletin, Vol. 14, Nr. 4 (2011), p. 161.

[75] Ibid.

[76] Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, UN Doc. A/HRC/22/53, 1 February 2013, paras. 14 - 16.

[77] Statement by the Special Rapporteur on Torture, "When a health carer becomes a torturer, key report by the UN Special Rapporteur on torture,"available at http://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=13073&LangID=E .

[78] Report of the Special Rapporteur on torture, UN Doc. A/HRC/22/53, para. 53 (footnotes omitted).

individual's suffering is of such a severity and the State was or should have been aware of the suffering and failed to take "[t]ake all reasonable steps to protect individuals' physical and mental integrity," there may be a violation of the CAT.[79]

Persons with psychosocial disabilities as well as those with intellectual disabilities are also subjected to severe abuses "[s]uch as neglect, mental and physical abuse and sexual violence" in health care settings.[80] Measures to eliminate these problems include, *inter alia*: ratification of the Convention on the Right of Persons with Disabilities; the application of an absolute ban on restraints and seclusion; and the revision of national legislation allowing for forced interventions.[81]

4. NPM-system in the Netherlands

4.1 NPMs and associates

The Netherlands signed the OPCAT on 3 June 2005 and ratified it on 28 September 2010. The ratification process was stalled due to a lack of capacity and priority.[82] According to the OPCAT, States Parties have to assign their NPM within a year after ratification of the treaty. The Netherlands exceeded the time between ratification of OPCAT and assignment of the NPMs due of the following factors. Firstly, The Netherlands already had a myriad of visiting and inspecting bodies covering a wide range of public and private bodies. While it was initially decided that the functions of the Netherlands would be performed by the collective action of existing bodies, the government still had to consider which existing bodies were OPCAT-compliant and which should be designated. Secondly, the Dutch government had to consider whether and how to coordinate the activities of the multiple bodies being considered for designation. Finally, the Dutch government decided that, to avoid gaps in coverage of places of detention, all organizations with an official task regarding monitoring detention should have a place at the table. Not all of those organizations complied with all of the OPCAT requirements. Thus, it was decided that besides appointing NPMs, some additional organizations were to be selected as associates ('toehoorder'). Those associates are formally appointed by the government and are allowed to join the NPM meetings and to give input.[83]

During 2010 and 2011, the government consulted relevant bodies about the composition of the Dutch NPM and the extent to which existing bodies complied with OPCAT. It firstly selected the Inspectorate for the Implementation of Sanctions (ISt) as coordinator, because

[79] Ibid., para. 54 (footnotes omitted).

[80] Ibid., para. 59 (footnotes omitted).

[81] Ibid., paras. 60 – 70.

[82] Dutch Parliament, 24 March 2010, TK 6767-5852.

[83] Monitoring places of detention, First Annual Report National Preventive Mechanisms, the Netherlands 2011, p. 13.

of its experience in visiting prisons. The ISt applied the following criteria in deciding which bodies should be designated:

- The statutory basis upon which the bodies operate give them unrestricted access to places of detention and to detainees, including the power to make unannounced visits, and unrestricted access to information about detainees and their conditions of detention (or at least contains nothing to prevent such access and such visits)
- Bodies should possess the independence, capability and professional knowledge to carry out visits.

On 22 December 2011, the Ministry of Security and Justice formally designated six bodies which would make up the Dutch NPM and assigned four additional members as associate.

The NPM of the Netherlands is made up of the following bodies:

- Inspectorate of Security and Justice (IVenJ) (the Public Order and Safety Inspectorate (IOOV) merged with the Inspectorate for the Implementation of Sanctions into the Inspectorate of Security and Justice in January 2012)
- Health Care Inspectorate (IGZ)
- Inspectorate for Youth Care (IJZ)
- Supervisory Commission on Repatriation (CITT)
- Council for the Administration of Criminal Justice and Protection of Juveniles (RSJ)

The additional associates ('toehoorders') include:

- Commission of oversight for penitentiary institutions
- Commission of oversight for the police cells
- Commission of oversight for military detention
- National Ombudsman.

5. Inventory of risk factors conducive to torture and IDT

In the context of the OPCAT, it is important to create a list of the risk factors that may be conducive to torture and IDT and that may exist in institutions in which individuals are deprived of their liberty against their will.[84] This chapter is concerned with the creation of a

[84] APT, Submission to the OHCHR questionnaire on the role of prevention in the promotion and protection of human rights, March 2011.

list of risk factors of inhuman treatment for individuals who are involuntarily held in health care institutions. Since certain conditions of detention in themselves may influence the state of health of a person deprived of his or her liberty, the chapter shall furthermore analyze which risk factors there are in relation to the state of heath of individuals detained in non-health care-specific institutions such as correctional institutions, migrant detention centers (including minors), and juvenile detention centers. Additionally, it will describe the type of monitoring that is required by the designated NPM on the listed risk factors. This list is not exhaustive.

5.1 Torture and inhuman treatment in health care settings

Firstly, it is important to establish whether certain treatment falls within the scope of 'torture', or 'cruel, inhuman or degrading treatment or punishment'.

In the Netherlands, the term 'torture' is avoided in the context of health care. Intent and purpose are generally lacking in such situations. As the Special Rapporteur on Torture, Juan E. Méndez concluded in his recent report, abuses in health care-related situations is usually defined as cruel and inhuman treatment. He infers that a number of treatments in national health care systems can lead to breaches of the Convention against Torture.[85]

Furthermore, Méndez argues on the basis of existing case law that, under certain circumstances, the term ´torture´ could be accurately applied in health care. This does not necessarily assume intent, but rather serious neglect, for instance in situations where pain treatment is denied:

"Medical care that causes severe suffering for no justifiable reason can be considered cruel, inhuman or degrading treatment or punishment, and if there is State involvement and specific intent, it is torture."[86]

In relation to persons with an intellectual disability, Méndez remarks that these individuals are frequently victims of a various forms of ill treatment. Examples of such treatment include neglect, mental and psychical abuse, as well as sexual violence in health care establishments. Isolation as a therapeutic treatment of this group of individuals should also be prohibited. Furthermore, more precise standards have to be implemented to regulate situations in which there is a lack of informed consent in medical treatment.

5.2 Risk factors for ill-treatment of persons deprived of their liberty in health care settings

5.2.1 The elderly

Ill treatment of the elderly

[85] Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, UN Doc. A/HRC/22/53, 1 February 2013.

[86] Ibid., para. 39.

According to estimates, 20,000 elderly people in the Netherlands fall victim to ill-treatment. Out of these estimations, a substantial part takes place within health care settings. Only 0.5 % of these abuses are reported.[87] These abuses can consist of bodily, psychic or sexual abuse, neglect or the withholding of certain rights through the interdiction of visitors or correspondence.

The IGZ (Inspectie voor de Gezondheidszorg, The Health Care Inspectorate**)** is the body responsible for the inspection of incidents concerning ill treatment of the elderly. In cases of the abuse of elderly people, staff members of the health care unit can file a complaint***. The office is part of the national action plan 'the Elderly in safe hands' ('Ouderen in veilige handen'). In the context of this action plan, the IGZ may adopt measures to encourage health care institutions to prevent abuse of the elderly more effectively. Moreover, the IGZ can file criminal complaints to institute proceedings against alleged culprits of elderly abuse. In extreme cases, where legally registered care attendants (under the Wet op de Beroep in de Individuele Gezondheidszorg, BIG – Law on Personal Health Care Services) are suspected of abuse of the elderly, the IGZ can initiate disciplinary proceedings at the board of medical examiners (medisch tuchtcollege).[88]

The elderly in secure geriatric units

Currently, individuals with a psychogeriatric ailment may be admitted to a care, or an elderly care home against their will on the basis of the Law on Exceptional Admittance in Psychiatric Hospitals (Wet Bijzondere opnemingen in psychiatrische ziekenhuizen, Wet Bopz).[89] In the future, one in five people is estimated to be affected by dementia. The problems with respect to the treatment of persons with dementia are large[90]

The IGZ approaches its supervision by firstly drawing attention to the risks of precarious or insecure health care. The Inspectorate conducts both unannounced and announced supervisory visits to those health care providers that are expected to pose the greatest risk. During the course of these visits, the IGZ pays close attention to the risk factors concerning precarious health care provision at the workplace. In this context, the most important elements of interest are: patient files, safety of medication, expertise and dedication of the personnel, and the deprivation of liberty.[91]

Restraints

[87] Source: www.igz.nl.

[88] www.igz.nl/actueel/nieuws/ouderenmishandelinggebeurtbijonsniet.aspx.

[89] Currently there are two projects of law to substitute the Wet Bopz. One draft law deals with care and coercion and is geared towards persons with dementia or a mental handicap, whereas the other draft law is on mandatory mental healthcare and is geared towards persons with psychological disorders.

[90] See among others http://deltaplandementie.nl/.

[91] http://www.igz.nl/onderwerpen/verpleging-en-langdurige-zorg/ouderenzorg/#alinea2, last visited 2 July 2013.

In care homes, it is common practice to tie down elderly people in order to prevent them from falling by, for instance, using a belt to restrain them to their wheelchair.[92] Such practices, however, are the cause of an even higher probability of falling: the fastening and the lack of movement leads to a weakening of bones and muscles, which further results in quick mental and bodily deterioration. Moreover, the tying down of elderly people has a negative effect on the physical, psychological and social functioning of the concerned individuals. Another consequence of this practice may even be the passing away of a person. Being restrained to or onto an object may lead to emotional insecurity and depression. According to the care organization 'Beweging 3.0',[93] tying elderly people to a wheelchair may amount to inhuman treatment. Distraction and human company are an essential aspect of recovery, which often cannot be provided. A problem in this relation is a lack of care personnel and their low salaries. There are various alternatives to restraining elderly people with a belt, such as low beds or the use of home automation, i.e. infrared systems and devices that signal movement.[94] Gulpers is of the opinion that restraining patients in care homes should and can be abolished with the so called EXBELT method (for more information on restraint measures, see paragraph 5.2.3).[95]

(Insufficient) treatment and use of antipsychotics

Insufficient treatment of pain for people with dementia is a widespread problem. Since these individuals are often unable to clearly describe their afflictions, they resort to obstructive behavior. In addition, even those individuals suffering from dementia who are still in the position to express their afflictions may be denied effective pain treatment.[96]

Such absence of pain treatment has dramatic consequences for the patient. Affected individuals suffer from pain, which may have further negative consequences on the progression of the disease. Additionally, pain may cause a change in behavioral patterns and/or depression.

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[92] Mariëlle ten Veldhuis, 'Feiten over fixeren' [Facts about restraints], 1 August 2008, www.innovatiekringdementie.nl/Artikel/Feiten-over-fixeren.aspx

[93] Interview with Beweging 3.0., 11 April 2013

[94] Vilans, 'Ruim 50 alternatieven voor vrijheidsbeperking in de zorg. Een praktisch hulp-en inspiratiemiddel bij het afbouwen van vrijheidsbeperking' [Over 50 alternatives for deprivation of liberty in health care. A practical guide for the reduction of deprivation of liberty], available at http://www.vilans.nl/docs/producten/alternatievenbundel.pdf, and M. Depla et al, 'Van fixaties naar domotica? Op weg naar 'goede' vrijheidsbeperking voor mensen met dementie' [From restraints to home automation? Underway to 'acceptable' deprivation of liberty for persons with dementia'], VUmc 2010.

[95] M. Gulpers, PhD Dissertation 'EXBELT: expelling belt restraints from psychogeriatric nursing homes', Maastricht, April 2013.

[96] B. Plooij, '(Under)treatment of Pain in dementia', 8 November 2012, http://dare.ubvu.vu.nl/bitstream/handle/1871/39339/title_page.pdf?sequence=8.

As an alternative to restraining patients with a belt, individuals are sometimes administered sedative medication, such as antipsychotics. According to the CBO (Centraal Begeleidings Orgaan voor de intercollegiale toetsing, Central Accompaniment Organization for peer review), the effect of antipsychotics is moderate and the probability of side effects is substantial.[97] In this context, it is important for the nursing staff to know their patients well in order to be able to accurately assess their behavior.[98] According to Van Marum, nursing staff should be trained to identify problem behavior. He adds that nursing homes should be required to keep records, which in turn should be controlled by the Health Care Inspectorate.[99]

Dehydration

Dehydration manifests itself in the terminal phase of dementia. Such situations do not fall within the scope of inhuman treatment in cases where dehydration is part of the natural process. However, situations where dehydration is a result of neglect could be categorized as inhuman treatment.

5.2.2 Persons with an intellectual disability

On the basis of the Wet Bopz, persons with an intellectual disability may be admitted to an institution against their will.

Sexual abuse

Persons with an intellectual disability become victims of sexual violence more frequently than persons without a disability ('double abuse'). A minority of the perpetrators are the professional providers of care.[100] Health care providers are obliged to report any ill-treatment by care personnel to the IGZ. The IGZ states that improper sexual conduct is frequently reported, especially in relation to the care of those with disabilities (for more information on the supervision by the IGZ, see paragraph 4.2.4).[101]

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[97] CBO Richtlijn Diagnostiek en medicamenteuze behandeling van dementie [CBO Guideline for diagnosis and choice of medication for the treatment of amnesia], 2005, http://www.cbo.nl/Downloads/387/rl_dement_2005.pdf, last visited 2 July 2013.

[98] Interview with Beweging 3.0., 11 April 2013

[99] Dr. R. van Marum, 'Geen pillen, maar scholing' [No pills, but education], 22 July 2008, IDé, http://www.innovatiekringdementie.nl/Artikel/Dr.-Rob-van-Marum-%E2%80%98Geen-pillen-maar-scholing.aspx, last visited 2 July 2013.

[100] Beperkt Weerbaar, 'Een onderzoek naar seksueel geweld bij mensen met een lichamelijke, zintuiglijke of verstandelijke beperking' [A research into sexual violence on persons with a physical, sensory or intellectual disability], 2011, Rutgers WPF/Movisie. http://www.rijksoverheid.nl/documenten-en-publicaties/rapporten/2011/11/14/rapport-beperkt-weerbaar.html

[101] Interview with the IGZ.

"Complex Care"

Health care institutions have become more reluctant to admit 'complex patients' – persons with both an intellectual disability such as autism and a psychiatric disorder. The reason for this reluctance lies in the fear of damage to their reputation as a result of negative press in cases where information has been leaked about a patient would have to be tied down.[102] One example that received considerable media attention is the Brandon case. Brandon, who was an 18 year old, intellectually disabled person, had been held on a leash, which was attached to the wall, for a period of three years in a care institution. Further investigation revealed that there have been more such cases. In 2011, another 28 cases comparable to Brandon were revealed.[103] The IGZ confirms that the quality and security of care provided at the visited locations were often questionable. As a reaction to these incidents, the Ministry of Health, Welfare and Sport (het ministerie van Volksgezondheid, Welzien en Sport, VWS) created a 'think tank for complex care/taskforce' (Denktank complexe zorg/ taskforce). This think tank is targeted at a small group of clients that are confronted with extremely complex behavioral problems that might to lead to drastic measures of deprivation of liberty.[104]

5.2.3 Restraint measures (Care services for the disabled and psychogeriatric patients)

On the basis of the Wet Bopz (Article 39), restraint measures are possible in order to bridge a temporary emergency situation. Such measures are intended to safeguard the safety of the patient concerned or of the other inhabitants of the hospital. Measures used for restraining patients, such as restraint belts or separating patients or placing them in isolation, are often employed to facilitate a secure environment. However, it has been known for a considerable time that the long-term application and inadequate supervision of these restraint measures can lead to serious physical and psychiatric harm. Moreover, such measures negatively affect the quality of life of elderly people and persons with an intellectual disability.[105]

For example, between June 2007 and May 2008, seven individuals died during attempts to free themselves from tie down belts. Four of these incidents took place in elderly care settings, one in care homes for intellectually disabled persons and two in one hospital. In comparison with countries such as Denmark, Switzerland and the United States of America, the Netherlands is lagging behind in the field of the application of restraint belts. In these

[102] De Volkskrant, 17 January 2013.

[103] IGZ: 'Kwaliteit van zorg bij langdurige vrijheidsbeperking van mensen met een verstandelijke beperking: vooral de dialoog ontbreekt' [The Quality of care of long term deprivation of liberty of persons with a mental disability: the dialogue is missing], November 2011.

[104] 'Wegen naar vrijheid: communiceren en methodisch (samen) werken in de zorg voor cliënten die ernstig in hun vrijheid worden beperkt,' [Roads to freedom: communication and methodological cooperation in the care of patients who are deprived of their liberty], Mid term report of the Denktank Complexe Zorg, June 2012.

[105] IGZ: 'Extra inspanning noodzakelijk voor terugdringen vrijheidsbeperking in langdurige zorg: Meer inzet externe deskundigen en betere focus op afbouw'[Additional efforts are necessary to reduce the deprivation of liberty in long term care: more efforts from external experts and additional focus on reduction], Utrecht, December 2012.

other countries, the use of such tie down belts is illegal, and recourse is made to less invasive alternatives.[106] According to Vilans, a research center for long-term care and the implementer of the project 'Ban de Band' (Ban the restraint belt), there are sufficient alternatives for institutions to provide secure health care. The draft law on care and coercion (wetsvoorstel zorg en dwang) provides for a limitation on the use of restraint belts to such situations where all other alternatives have failed and where the patient is expected to pose a danger to him/herself. It should furthermore be mentioned that according to the draft law, the risk of injury through falling would not be categorized as posing a danger of harming him/herself'.[107]

In 2008, the stakeholders in the fields of services for the intellectually disabled, care homes for the elderly, as well as the IGZ signed a letter of intent entitled ''Care for Liberty; Together towards less restraints" ("Zorg voor vrijheid; samen naar minder vrijheidsbeperking"). The declaration promotes an abolishment of restraint belts by 2011. Only exceptional situations may lead to the use of belts that must fulfill strict quality criteria. Another aspired goal is the drastic reduction of all types of restraint measures in 2011. By 2009, participants of the project had already demonstrated the feasibility of reducing the use of restraint belts. The 30 organizations taking part in the project managed to reduce the use of such belts from 334 to 120 times. At the end of 2012, the IGZ stated that providers of health care and care personnel were demonstrably working to implement the objectives of the initiative. At the same time, the IGZ concluded that the decision to implement a restraint measure needs to be taken with more due care. An important step in this direction is the involuntary care action program (Actieprogramma onvrijwillige zorg), which was introduced by the Ministry of Health, Welfare and Sports.[108]

According to Beweging 3.0, it is quite positive that the IGZ has been involved in this matter. Thus, the Government developed a central policy for mental health care, after the IGZ established the absence of one. Twice a year, this Inspectorate offers a platform for multidisciplinary exchange to identify risk factors within the sphere of health care establishments.

5.2.4 Persons with a psychiatric disorder

In cases where persons with a psychiatric disorder are admitted to a health care institution against their will, the Wet Bopz is the applicable law.

Sexual abuse

[106] IGZ, 'Zorg voor vrijheid: terugdringen van vrijheidsbeperkende maatregelen kán en moet' [Care for freedom: reducing measures for deprivation of liberty is possible and necessary], The Hague, November 2008, p. 10.

[107] IGZ: 'Extra inspanning noodzakelijk voor terugdringen vrijheidsbeperking in langdurige zorg - Meer inzet externe deskundigen en betere focus op afbouw', Utrecht, December 2012.

[108] Letter of the Secretary of State of the Ministry of Health, Welfare and Sports to the Chairperson of the Dutch Parliament dated 17 May 2013, reference nr. DLZ/KZ-3156923.

Sexually offensive behavior or abuse also occurs in mental health care. This is apparent in the IGZ's inspection reports.[109] The Inspectorate follows the policy "it is not allowed, it should never be allowed" for inappropriate sexual conduct and sexual abuse.[110] Applicable **primary** preventative measures against such conduct are: specific policy, training of professionals, and interviews and protocols. The IGZ devotes a lot of attention to this issue. In cases where legally registered health care attendants commit such abuse, a disciplinary process is initiated. However, the exposure of sexual abuse and related behavior is often problematic. While the IGZ is in close contact with the public prosecutor, it is the patient's responsibility to report any abuse. Disciplinary or criminal proceedings may have further **secondary** preventative effects. It is possible for the perpetrator to be precluded from exercising their profession, or to be prohibited from working in certain places.

Coercive and other measures

The Wet Bopz provides a comprehensive list of coercive or other measures that may be applied to patients. The most controversial of such measures is segregation, which is often applied in the Netherlands. This widespread application is striking compared to the neighboring countries. Patients perceive segregation from others as negative or even traumatizing.[111]

In order to approve the segregation of a patient from others, it first has to be assessed whether there is an emergency based on acute and unexpected endangerment. Besides segregation, there are other measures: isolation, restraining, medication or the administration of liquids and nourishment. Health care providers have to choose the measure which is the least invasive, most proportional and most effective. The negative effects of segregation on the patients are diverse. These include fear, disorientation, humiliation, a feeling of punishment, loneliness and helplessness, loss of track of time, and boredom. On the other hand, the patient might experience positive effects, for instance a feeling of security, calmness and protection.[112]

The IGZ confirms that segregating patients may have a beneficial effect on their well-being. This is especially so because the common alternative to separation is usually forced medication. Some patients chose segregation instead of forced medication. It lies within the competence of the psychiatrist to assess whether the patient is in a position to make independent and reasonable choices.[113]

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[109] http://www.rijksbegroting.nl/2013/kamerstukken,2012/10/25/kst174763.html

[110] According to the IGZ, this is old policy which will be subjected to review.

[111] F.E. Welles, '*Dwang: separatie versus medicatie. De ingrijpendheid van dwangmiddelen in de psychiatrie vanuit patiëntperspectief*' [Coercion: segregation versus medication. The intrusivness of coercive meaures in psychiatry from the patients' perspective], Stichting PVP, Utrecht, http://www.pvp.nl/downloads/onderzoek-naar-dwangmiddelen.pdf

[112] http://psychiatrie-nederland.nl/word/alternatieven-voor-gedwongen-separatie/

[113] Interview with the IGZ.

A new development in the sphere of psychiatric institutions is the development and construction of comfort rooms. A comfort room is a retreat area to which patients may take recourse in order to find rest in time of agitation. Some establishments offer intensive care units instead of segregation rooms. An intensive care unit is a small living space, furnished with, for example, a bed, a couch and a table.[114]

The Committee against Torture has expressed its concern about the large number of patients with a psychiatric disorder in the Netherlands who have been forcibly institutionalized, mostly for a long period of time. In addition, the Committee is concerned about the frequent use of restraining means and measures, and forced medication, which according to the Committee can lead to inhuman treatment.[115]

Monitoring

Since 2012, the IGZ has campaigned for the abolition of segregation within mental health care, except when the health care provider can prove the urgent necessity of such treatment. When applied, segregation should be limited to the shortest period possible and in the most humane manner (no solitary confinement). For periods of segregation lasting longer than one week, a system of regular consultation exists. The intensity of the mandatory consultation is tailored to the concerned time span of the segregation. A reduction in the use of freedom-restricting measures is quite possible.[116]

In the past couple of years, the IGZ has conducted regular visits to institutions that apply segregation as a measure. The IGZ's inspection of institutions has taken place at random, and visits have been both announced and unannounced.

5.3 Risk factors for inhuman and degrading treatment or punishment in other institutions involving the deprivation of liberty with health care components

5.3.1 Minors

JeugdzorgPLUS and juvenile detention institutions

Minors with substantial behavioral problems may be placed in so-called "JeugdzorgPLUS" (JZ+, Dutch youth welfare system) institutions. These institutions offer aid in a closed environment. A minor may be admitted without consent after a juvenile court judge has

[114] For an example of a segregation room in new style provided by the Parnassia Bavo Groep please see http://www.youtube.com/watch?v=CnF0jHwoxl0

[115] Committee against Torture, Concluding observations on the combined fifth and sixth periodic reports of the Netherlands, adopted by the Committee at its fiftieth session (6-31 May 2013).

[116] IGZ, 'Terugdringen separeren stagneert, normen vereist rondom insluiting psychiatrische patiënten' [The reduction of segregation is stagnating, regulations are necessary with respect to the internment of psychiatric patients], Utrecht December 2011.

adopted a decision. Young offenders that have been criminally convicted by a court are usually placed in juvenile justice institutions, called justitiële jeugdinrichtingen (JJI's).

The Dutch youth welfare code (Wet op de Jeugdzorg) provides for certain measures limiting liberty, such as isolation. The Dutch Inspectorate for Youth Care (Inspectie Jeugdzorg, IJZ) is a proponent of a minimum level of limitation of liberty for minors. JZ+ provides concerned minors with confidants and there is a special commission responsible for handling complaints. It is the competence of these organs, amongst other things, to decide upon measures limiting liberty. An appeal may be lodged with the Council for the Administration of Criminal Justice and Protection of Juveniles (Raad voor Strafrechtstoepassing en Jeugdbescherming, RSJ).

The IJZ names the following practices as examples of torture, inhuman or degrading treatment or punishment:[117]

- illegitimate detention;
- harassment;
- withholding of certain rights;
- excessively long isolation;
- minors punishing other minors;[118]
- disproportionate application of liberty limiting measures;
- broken arms through the inappropriate application of measures to apprehend and restrain minors;
- inappropriate sexual conduct by care personnel.

Monitoring

The IJZ has gradually implemented a multiple-year-program in the context of which, it conducts annual visits to the 16 JZ+ institutions. Out of the 10 juvenile justice institutions, three institutions are visited per year, whereby the setting and its environment are assessed. Moreover, the IJZ conducts theme-based inspections of the juvenile justice institutions. During the period 2008 to 2011, a comprehensive topic-based research took place together with follow-up inspections in all institutions.

Inhuman treatment and torture are risk indicators for the IJZ.[119] Once such a risk has been identified, the IJZ acts accordingly and conducts a specific visit to the concerned institution, which may have further implications for the theme-based monitoring.

Calamities, such as death, aggression and inappropriate sexual conduct may all qualify as IDT and could cause considerable harm to the minor. For that reason, the IJZ Guidelines on

[117] Interview with IJZ.

[118] This happens in De Sprint, an enclosed youth care institution. See http://www.inspectiejeugdzorg.nl/documenten/Rapport%20Entreetoets%20De%20Sprint.pdf

[119] Interview with the IJZ.

calamities require immediate reporting to the Inspectorate for their assessment.[120] In 2012, the juvenile justice institutions and the JZ+ institutions reported around 25 calamities.

In almost all cases, inspections by the IJZ in relation to calamities take place together with other inspecting bodies. During these combined inspections, the different inspectorates use the same terms of reference.

The new youth care system

A major development in youth care is the transition to a new youth health care system in 2015. In the new system, more emphasis is put on preventative actions. Moreover, all tasks are transferred to (cooperating) municipalities. This will have major consequences for youth care and those who work in this field.

Sexual abuse

The Samson Commission, which was established in 2010 at the behest of the Ministry of Youth and Family as well as the Ministry of Justice, researched the sexual abuse of children taken out of their homes and placed into institutions and foster homes. The research shows that since 1945, children who are taken out of their home as the result of a juvenile court's judgment have not always been provided with adequate protection against sexual abuse, even though they have the right to protection. Children who are placed in a residential facility by the Government are reported to be 2.5 times more likely to be the victims of sexual abuse than children who are placed in foster care. It also appears that professionals process less than 2% of the cases of sexual abuse reported by concerned children themselves.[121]

As a response to the reports of the Deetman[122] and the Samson Commissions, the Government established a national hotline for victims of sexual abuse.[123]

Minors in pre-deportation detention

As a rule, it is not permitted to release minors on the street. For families awaiting deportation, there are two reception centers in the Netherlands, namely in Katwijk and in Gilze. However, the Dutch branch of Unicef and Defence for Children have declared that these reception

[120] 'Leidraad melden van calamiteiten, Onderzoek van de Inspectie Jeugdzorg naar aanleiding van meldingen van calamiteiten' [Guidelines for reporting calamities; research by de Youth care inspectorate on account of reports of calamities], Utrecht, November 2011.

[121] Report of the Commissie Samson, '*Omringd door zorg en toch niet veilig*' [Enclosed by care, yet not safe], 8 October 2012, available at http://www.onderzoek-seksueel-kindermisbruik.nl/actueel/20121008-rapport-omringd-door-zorg-toch-niet-veilig-openbaar.aspx

[122] The Deetman Commission carried out research on sexual abuse by the Catholic Church.

[123] https://www.hulplijnseksueelmisbruik.nl/.

centers are unsuitable for children.[124] According to their report, such centers are inappropriate to guarantee the right to (mental) health care.

The Children's Ombudsman (Kinderobmudsman) observes that any detention of underage foreign nationals should only be applied on a short-term basis. The Children's Ombudsman has requested the responsible authorities, *inter alia*, to monitor whether the application of deprivation of liberty is appropriate in all situations, since special circumstances must be shown to exist if the measure is to be applied.[125]

Children in police cells

According to the organization Defence for Children, Dutch legislation, policy and practice regarding the custody of juvenile suspects in police cells does not meet the requirements of the UN Convention on the Rights of the Child, because it exceeds the statutory maximum period of police custody for minors.[126] Additionally, the monitoring of the conditions of minors in police cells is inadequate and a national assessment framework is lacking.

The National Ombudsman and the Children's Ombudsman concluded that, when kept in a police cell, minors must be granted unrestricted physical contact to their parents during visits. This is not always the case.[127]

5.3.2 Medical care in correctional institutions

In the Netherlands, there are four types of correctional institutions: penitentiaries, correctional institutions for minors, forensic psychiatric centers and detention and deportation centers for foreigners. Five of these penitentiaries are equipped with Penitentiary Psychiatric Centers (PPCs). These clinical psychiatric centers provide care to detainees with psychiatric problems and addictions who cannot be attended sufficiently within the regular health care settings available at the penitentiaries. According to Article 22 of the Dutch Constitution, the Government has to ensure the right to health to those who are deprived of their liberty. This

[124] 'De gezinslocaties in Gilze Rijen en Katwijk: geen plek voor een kind' [The family reception centers in Gilze Rijen and Katwijk: no place for a child], December 2011, http://www.defenceforchildren.nl/p/21/2236/mo89-mc21

[125] De Kinderombudsman, Kinderrechtenmonitor 2012, http://www.dekinderombudsman.nl/329/volwassenen/publicaties/?id=153, last visited 1 july 2013.

[126] Maartje Berger and Carrie van der Kroon, 'Een 'paar nachtjes' in de cel: Het VN-Kinderrechtenverdrag en het voorarrest van minderjarigen in politiecellen' [A couple of nights in the cell: the UN Convention on the Rights of Children and the pre-trial detention of minors in police cells], Defence for Children, August 2011.

[127] 'Bezoek van ouders aan minderjarigen in politiecellen' [Visits by parents to minors in police cells], Report by De Kinderombudsman en de Nationale Ombudsman, 13 February 2012, Rapportnummer Nationale ombudsman:2012/017, Rapportnummer Kinderombudsman: KOM001/2012.

includes the availability, accessibility, acceptability, and quality of health care.[128] Article 3 of the ECHR obliges the government to take adequate measures to ensure detainees' health and welfare. A lack of medical care (inadequate or untimely care) can lead to a violation of the prohibition of torture and other cruel, inhuman or degrading treatment or punishment.[129] Furthermore, the so-called principle of equivalence is applicable: the quality of medical care during times of detention should be equivalent to the medical care available outside of detention.[130]

Monitoring

The IGZ concluded in 2009 that there is room for improvement in the sphere of medical care in penitentiaries.[131] However, after a follow-up round in 2011, the IGZ pointed out that the previously identified risks had decreased substantially and that medical care in the visited prisons meets the standards of responsible health care.[132]

In one of its advisory reports, the Council for the Administration of Criminal Justice and Protection of Juveniles (Raad voor Strafrechtstoepassing en Jeugdbescherming, RSJ) calls for attention to the provision of care to detainees with a mental disorder, a mild intellectual disability or addiction problems during the period of their detention. Those psychological problems amongst prisoners are serious and extensive. Most of the detainees suffer from a personality disorder, addiction problems, mild intellectual disability or combinations thereof. According to the Council, only a small proportion of the concerned persons receive appropriate treatment during their detention. Given the seriousness and extent of the problem, the Council considers it desirable to further develop forensic care in places of detention.[133]

Death in custody

[128] Committee on Economic, Social and Cultural Rights, General Comment No. 14 (2000), The right to the highest attainable standard of health, par. 12.

[129] .D.C. Roscam Abbing, 'Prisoners right to Healthcare, a European perspective', *European Journal of Health Law*, Volume 20, Issue 1, 2013, p. 5-19, CPT-standards, CPT/Inf/E/ (2002) 1 – Rev. 2011.

[130] See further M. Hagens, 'Toezicht op menswaardige behandeling van gedetineerden in Europa. Een onderzoek naar de verhouding tussen het EHRM en het CPT bij de effectuering van het folterverbod' [The monitoring of human treatment of persons deprived of their liberty in Europe. A reseach on the relationship between the ECHR and the CPT in the implementation of the prohibition of torture], Meijers-Reeks nr. 198, Leiden, 2011.

[131] IGZ, 'Medische diensten in penitentiaire inrichtingen: achter tralies nu veiliger zorg, maar verbeteringen nog nodig', [Medical services in penitentiary insitutions: safer health care behind bars, but improvements are still necessary], The Hague, June 2009.

[132] *Kamerstukken II*, 24 587, nr. 435 (Dutch House of Representatives official documents).

[133] Raad voor de Strafrechtstoepassing en Jeugdbescherming, 'Forensische zorg tijdens detentie' [Forensic care during detention], 27 September 2012.

In 2011, forty deaths were registered in the above-mentioned establishments, out of which fifteen were suicides. In 2012, the number of deaths decreased to twenty-four, out of which nine were suicides.[134] The National Ombudsman observes that all cases that deal with suicide have a link with the assessment of inhuman treatment.[135] The prospect is then whether the concerned Inspectorates conduct an independent investigation of the incidents, which bereaved people can rely upon in relation to Article 2 of the ECHR (right to life in respect of care for the detainees).

Death during custody/detention is regarded as 'a special situation', because the detainee passed away during the time of deprivation of his or her liberty. Upon his/her death, an investigation must take place as to whether the concerned public authority had provided the detainee with the relevant health or mental care. The National Ombudsman has concluded that the manner in which death during detention in a penitentiary institution is investigated does not always meet the standards of due diligence.[136]

Correctional institutions should report all cases of deaths in custody to the IGZ that then assess the care provided by the medical service. For these type of situations, the IVenJ adopted a coordinating role in 2012.

5.3.3 Detention of foreigners

Regime

Foreigners who are not in possession of a residence permit are not entitled to remain in the Netherlands. If such a person does not depart of his or her own accord, the government can place him or her in a detention center in order to ensure that the foreigner leaves the Netherlands as soon as possible.

Detention pending deportation is set up as a regime which was originally only intended for people serving a sentence as a result of criminal proceedings. The conditions of detention pending deportation are simpler than in criminal detention, since activities which focus on rehabilitation, such as education, employment and leave of absence, are not applicable. According to the National Ombudsman, factors such as the sober living environment, the restrictions in the freedom of movement, contact with the outside world, family life, and the

[134] http://www.rijksoverheid.nl/nieuws/2012/11/26/coordinerende-rol-inspectie-veiligheid-en-justitie-bij-overlijden-in-detentie.html.

[135] Interview with representative National Ombudsman.

[136] Nationale Ombudsman, 'Overlijden in detentie' [Death in custody], 12 April 2012, report number 2012/037.

partaking in meaningful activities, are at odds with the prohibition of inhuman or degrading treatment of Article 3 of the ECHR.[137]

The call for more humanity in detention pending deportation has been voiced in the Netherlands for a while.[138] Measures affecting the health of foreigners in detention are primarily intended for the maintenance of security. Examples of such measures are body cavity searches, handcuffing,[139] isolation and the 'broekstok' (a stick attached to a detainee's leg, which prevents them from running away). According to the National Ombudsman, body cavity searches constitute a source of complaints.[140] Pharos indicates that the necessity of the measure is often not scrutinized by considering the potential health consequences.[141] Moreover, Pharos believes that the pre-detention phase, where people are held in cells for a couple of days, is often experienced as inhuman/degrading.

Since the establishment of the Immigration Detention Hotline, there have been 161 official communications containing 274 complaints. The complaints are mainly in relation to medical care, isolation from the outside world, and the use of coercive measures and harassment.[142]

Medical care in detention centers (pre-deportation detention)

According to Pharos, there are signs of poor health care provision in detention centers.[143] It is of the utmost importance that health care is appropriate. It may be justified to delay care if there is a medical justification for it. However, in many cases the commencement of treatment in cases of chronic diseases is delayed or absent, because the foreigner is in a transitory phase and therefore about to leave the center. In some cases, persons remain in detention for a longer period without receiving treatment for their illness. Moreover, continuity of treatment is a problem in detention centers. The protection of health is in almost all cases

[137] Nationale Ombudsman, 'Vreemdelingenbewaring: strafregime of maatregel om uit te zetten. Over respect voor mensenrechten bij vreemdelingenbewaring' [Detention of migrants: criminal regime or a measure for deportation: on the respect of human rights with regards to the detention of foreigners] 7 August 2012, 2012/105, p. 31.

[138] See for example, Prof. Dr. A.M. van Kalmthout, afscheidsrede ''Illegalen' in detentie: Minimale rechten of minimale beperkingen?' [Illegal migrants in detention: minimal rights or minimal restrictions], 1 July 2010; Amnesty International, the Netherlands: the detention of irregular migrants and asylum-seekers, EUR 35/02/2008, June 2008; Nationale Ombudsman, 'Vreemdelingenbewaring: strafregime of maatregel om uit te zetten. Over respect voor mensenrechten bij vreemdelingenbewaring.'

[139] See also the report by the Nationale Ombudsman of 14 December 2010, 2010/353 on the use of disproportional force during a sit-in demonstration by foreigners in the pre-deportation center at Schiphol Airport.

[140] Interview with representative of the National Ombudsman.

[141] Interview with representative of Pharos, 10 March 2013. According to Pharos, an example of IDT is visits of handcuffed pregnant women to the gynecologist.

[142] http://www.meldpuntvreemdelingendetentie.nl

[143] Interview with representative of Pharos, 10 March 2013.

subordinate to the 'regime', which according to Pharos leads to situations that result in inhuman treatment or are experienced as such. In addition, there are complaints regarding access to health care. While there is general access to care, all health care issues first have to be run by a nurse. Serious complaints are sometimes trivialized and therapies as well as other treatment are cancelled abruptly.

Pharos observes that access to health care in detention centers for families awaiting deportation is a difficult process: sometimes concerned individuals need to return to the responsible care giver several times before being helped.

Moreover, a study by the National Ombudsman shows that foreigners in pre-deportation detention centers complain that they are not, or inadequately, or not timely treated for their health ailments.[144]

Monitoring

As for the medical care in detention centers, the IGZ ruled in 2009 that health care in detention centers is organized in such a way that it provides safe and responsible care. The IGZ has further identified certain bottlenecks that that can lead to reduced access to skilled care or a reduced continuity of care and thus may lead to an increase in health related risks. These difficulties may pose potential or actual risks. The quality assurance of care and the availability of appropriate and qualified staff require improvement.[145] In this regard, the IGZ has initiated a number visits to all detention and deportation centers in early 2013 in order to assess whether the recommendations in the report have been adequately implemented.

Suicide in pre-deportation detention

In early 2013, Mr. Aleksandr Dolmatov, a Russian citizen, died in his cell in the Rotterdam detention center, where he stayed in connection with his planned deportation to Russia. The IVenJ examined whether the government acted with due diligence at the time Mr. Dolmatov was taken into custody, and during the time of his detention. Complimentary, the IGZ investigated whether the quality of the (organization of) care, such as that offered by the institutions and individual workers met the requirements of responsible care. The IVenJ concluded that the various organizations involved in the migrant detention process acted negligently at different times. In particular, the provided medical care had not been sufficient.[146] The Secretary of State of the Ministry of Security and Justice has accepted all recommendations by the IVenJ in order to strengthen the immigration process and prevent the reoccurrence of such an incident.

5.4 Developments in healthcare: cuts in healthcare spending and privatization

[144] Nationale Ombudsman, 'Vreemdelingenbewaring: strafregime of maatregel om uit te zetten. Over respect voor mensenrechten bij vreemdelingenbewaring,' p. 23.

[145] IGZ, 'Medische diensten in detentiecentra: verantwoorde zorg, maar nog niet geborgd' [Medical services in detention centers: responsible care, but not yet secured], The Hague, December 2009.

[146] Inspectie voor Veiligheid en Justitie, 'Het overlijden van Dolmatov' [The death of Dolmatov], 28 March 2013.

Cuts in healthcare spending can have a detrimental effect on the quality of healthcare services and may ultimately result in more ill-treatment in healthcare settings. For care to be humane financial and human resources are required so that sufficient time can be spent on the patient. Our respondents have pointed out that fewer personnel or insufficiently qualified personnel can lead to less humane care. To give an example provided by *Beweging 3.0*: 'persons with dementia need distraction and company, however it is not always possible to offer this type of care. Persons with dementia who are detained in a wheelchair and are subsequently neglected suffer more from anxiety and loneliness'.[147]

The Dutch health care system has been reorganized dramatically over the course of the past decennia. A system of regulated competition has been introduced, creating a private health insurance market where the private health insurance companies have become the key actors in the health sector. These developments have an effect on healthcare supervision. Health insurance companies have obtained an increasingly important role when it comes to regulating the quality of care.[148] Ultimately, however, based on the Dutch Constitution and international human rights law healthcare supervision remains the responsibility of Government.[149]

6. Research findings

This chapter describes how the NPMs function with respect to health care-related institutions. The findings are mainly based on a number of interviews that were conducted for the purposes of this research project. This chapter will start with an analysis as to whether the Netherlands NPMs meet the requirements of the OPCAT.

6.1 Do the NPMs meet the requirements of the OPCAT?

Multiple NPMs?

During the interviews, some confusion arose as to whether there was a single or several NPMs in the Netherlands. The heading of the letter from the Dutch Secretary of State of the Ministry of Security and Justice addressed to the involved parties was 'Designation of the National Preventive Mechanisms (NPMs) on the basis of UN OPCAT.' Additionally, the NPM's 2011 annual report speaks of NPMs in the plural. However, during an interview with a representative of the IVenJ, it was mentioned that a single NPM had been designated in the Netherlands, which is confirmed on the IVenJ's website.[155] According to an interview with a

[147] Interview with Beweging 3.0, 11 April 2013.

[148] See also J.H. Hubben: 'De IGZ: van stille kracht naar publieke waakhond' [The Dutch Health Inspectorate: from a silent force to a public watchdog], *TvGR* 2012 (36), pp. 96-108.

[149] Article 22-1 Constitution, and for international provisions by which the Netherlands is bound see *inter alia* Article 11 European Social Charter and Article 12 International Covenant on Economic, Social and Cultural Rights.

[155] http://www.ivenj.nl/onderwerpen/nationaal_preventiemechanisme_(NPM)/.

representative of the RSJ, this confusion can still be addressed through meetings with the organizations participating in the NPM context.[156] It essentially does not make a difference whether there is one or multiple NPMs: even if a single NPM is decided upon, all related organizations must adhere to the guidelines of the OPCAT.

Mandate

1. The mandate and powers of the NPM should be clearly and specifically established in national legislation as a constitutional or legislative text.[157] The visiting mandate of the NPM should extend to all places of deprivation of liberty, as set out in Article 4 of the Optional Protocol.[158]

When it comes to their mandate, the designated NPMs seem to comply with the terms of the OPCAT.[159] Only the mandate of the RSJ no longer includes monitoring. While the RSJ is authorized to enter any premises where people are deprived of their liberty, this authorization is not derived from its tasks as a monitoring organ, but rather from its advisory and judicial tasks.

In the wake of the NPMs' designation though the letter from the Secretary of State, there have been no legislative initiatives that would define the mandate and powers of NPMs. In New Zealand, which also has system of multiple NPMs, the "Crimes of Torture Act 1989" has been amended to ensure that the organizations identified as NPMs are bound by the requisite powers and duties.[160] According to the interview with a representative of the IVenJ, it would be better if a law regulated the mandate of the NPMs.[161] Members of the SPT insist that the mandate of the Dutch NPMs should be regulated by constitutional law.[162] The mandate of NPMs should be derived from parliament and not from a ministerial regulation that can be changed easily. Another aspect is the lack of consultation of civil society organizations in the debate concerning the designation of NPMs.[163] In spite of this, the Dutch Section of the International Commission of Jurists (NJCM) recommends that the Dutch

[156] Interview representative RSJ, 23 April 2013.

[157] SPT Guidelines, para. 7.

[158] SPT Guidelines, para. 10.

[159] S. van Gerven-Mandjes, 'Het Nederlandse Nationaal Preventiemechanisme langs de OPCAT-lat', *NJCM-Bulletin*, jrg. 36 (2001), nr. 6, p. 854 – 855.

[160] OPCAT in New Zealand 2007-2012, A review of OPCAT implementation by New Zealand's National Preventive Mechanisms, April 2013, p. 9

[161] Interview with representative of IVenJ, 26 March 2013.

[162] Interview with members of the SPT, 20 June 2013.

[163] See also SPT Guidelines, para. 16.

government still pursue consultation and engagement with civil society organizations on this topic, and perhaps even allow the participation of these organizations in the NPMs.[164]

Functional and personal independence

2. The operational independence of the NPM should be guaranteed.[165] The State should ensure the independence of the NPM by not appointing to it members who hold positions which could raise questions of conflicts of interest.[166]

The independence of the NPMs is a particular focus of attention. A number of the Inspectorates form organizational units within Dutch ministries. The Inspectorates function within the limits of ministerial responsibility. For instance, the Secretary of State of the Ministry of Security and Justice appoints the staff of the IVenJ. In addition, their annual reports have to be submitted to the Minister of Security and Justice.

Van Gerven concludes that the functional and personal independence of the ISt (now IVenJ) should be secured more effectively. In addition, she observes that there is a need to secure the personal independence of staff of the IJZ, CITT and the IGZ in a more effective manner.[167] According to the National Ombudsman, the NPMs have to demonstrate their independence through their conduct.[168] The Netherlands Institute for Human Rights (College voor de Rechten van Mens) has no doubts about the integrity and independence of the inspections, but is worried about perceived independence. The Netherlands Institute advises the Government to guarantee the independence of these bodies.[169] The APT believes that the perceived independence of NPMs is of special importance for both individuals who are detained against their will, and the staff of centers of detention.[170]

In particular, with respect to the perception from outside the Netherlands, the perceived independence of NPMs may be problematic. The chairman of the SPT, for example, detected a 'double problem' in relation to perceived independence when it comes to the coordination by the IVenJ: the IVenJ, which falls under ministerial responsibility, coordinates

[164] Commentary on the sixth periodic report submitted by the Kingdom of the Netherlands on the implementation of the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UN Doc. CAT/C/NLD/Q/6), Dutch Section of the International Commission of Jurists (NJCM), May 2013.

[165] SPT Guidelines, para. 8.

[166] SPT Guidelines, para. 18.

[167] Van Gerven, *supra* note 159, p. 860 – 865.

[168] Interview with representative of the Dutch National Ombudsman, 23 April 2013.

[169] College voor de Rechten van de Mens, *The Netherlands Institute for Human Rights Submission to the UN Committee against Torture on the Examination of the sixth Periodic Report of the Netherlands in May 2013*, p. 12.

[170] Interview with representative of APT, 20 June 2013.

organizations which themselves fall under ministerial responsibility.[171] In its recent concluding observations to the Netherlands' combined fifth and sixth periodic report under the Convention against Torture, the Committee Against Torture expressed its concerns about the perceived lack of independence and recommended the State Party to,

> "Ensure and respect complete financial and operational independence of the NPM, both factual and perceived, when carrying out its functions, in accordance with article 18, paragraph 1, of the Optional Protocol and the Subcommittee on Prevention on Torture 's "Guidelines on national preventive mechanisms", with due regard to the Paris Principles."[172]

Financial independence

3. The necessary resources should be provided to permit the effective operation of the NPM in accordance with the requirements of the Optional Protocol; The NPM should enjoy complete financial and operational autonomy when carrying out its functions under the Optional Protocol.[173]

Our research suggests that the NPMs do not meet the requirement of financial independence of the OPCAT. The organizations were not provided with additional funds or manpower for their NPM-specific tasks. They have to work with the resources that they currently have. The recommendation of the SPT to Sweden, where NPMs were also not provided with an extra budget, reads as follows:

'The SPT emphasizes that to be in a position independently to exercise the minimum powers assigned to it in article 19 OPCAT an NPM must have structures equipped with the human, material and financial resources which will enable it to function satisfactorily in the light of the number and distribution of places of detention (OPCAT, article 4) and the numbers of persons to be visited regularly and with a periodicity which is reasonable for adequate monitoring'.[174]

The NPMs have the possibility to request support from the SPT in addressing this requirement to the Government. The SPT can question the Dutch government for clarification.[175]

The NJCM suggests placing the NPMs under the supervision of the Netherlands Institute for Human Rights. In any case, the NJCM suggests that the NPMs' own budget should be kept

[171] Interview with chairperson of the SPT, 20 June 2013.

[172] Concluding observations on the combined fifth and sixth periodic reports of the Netherlands, adopted by the Committee at its fiftieth session (6-31 May 2013), Committee Against Torture, UN Doc. CAT/C/NLD/CO/5-6, 20 June 2013, para. 28.

[173] SPT Guidelines, paras. 11 and 12.

[174] *Report on the visit of the SPT to Sweden,* CAT/OP/SWE/1, p. 9.

[175] Interview with members of the SPT, 20 June 2013.

separate from the budget of the ministries and that there should be sufficient budget allocated for the tasks of the NPMs.[176]

Expertise

Recalling the requirements of Articles 18 (1) and (2) of the Optional Protocol, the NPM should ensure that its staff have between them the diversity of background, capabilities and professional knowledge necessary to enable it to properly fulfil its NPM mandate. This should include, inter alia, relevant legal and health-care expertise.[177]

One of the challenges with regard to visits to places of detention is the need for sufficient expertise when executing OPCAT visits. In order to render a preventive visit effective, a multidisciplinary team must carry it out. This applies to all places of detention.[178] For instance, psychiatrists and other mental health experts are better equipped to monitor psychiatric institutions than a lawyer. The same applies to youth care and geriatrics.

All NPMs taken together appear to have at their command sufficient expertise to function as NPM. There is no indication that specific training is given to NPMs.[179]

Are all places of detention covered?

4. The NPM should establish a work plan/programme which, over time, encompasses visits to all, or any, suspected, places of deprivation of liberty, as set out in Articles 4 and 29 of the Optional Protocol, which are within the jurisdiction of the State. For these purposes, the jurisdiction of the State extends to all those places over which it exercises effective control.[180]

It is important to cover all actual and potential detention places. The first annual report of the Dutch NPM for the year 2011 contains a list of detention centers under OPCAT-supervision. This list does not contain any settings related to health care. The second annual NPM report will contain such a list.[181] According to the IGZ it is difficult to draft up such a list: sometimes persons are forcibly institutionalized, sometimes they are not.[182] The SPT emphasizes the importance of the mapping of these so-called gray areas in health care to ensure that all potential places where people are held against their will are under OPCAT-supervision.[183]

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[176] NJCM, 'Commentary on the sixth periodic report submitted by the Kingdom of the Netherlands on the implementation of the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment', UN Doc. CAT/C/NLD/Q/6.

[177] SPT Guidelines, para. 20.

[178] *Visiting places of detention. What role for physicians and other health professionals?* APT, 2008.

[179] See SPT Guidelines, para. 31.

[180] SPT Guidelines, para. 33.

[181] Interview with representative of the IGZ, 4 April 2013.

[182] Interview with representative of the IGZ, 4 April 2013.

[183] Interview with members of the SPT, 20 June 2013.

6.2 How have the NPMs functioned so far?

6.2.1 Functioning in general

Methods for conducting visits and frequency of visits

(i) The periodicity of NPM visits should ensure effective monitoring of such places as regards safeguards against ill-treatment;

(ii) Working methods of NPMs should be developed and reviewed with a view to effective identification of good practice and gaps in protection.[188]

The first NPM annual report of the Netherlands (2011) provides a general overview of the tasks and competences of the organizations that have been designated as an NPM. Thus far joint NPM-activities have not been developed. The organizations have not adjusted their approach as a result of their designation as an NPM.[189] Three NPMs mention their position as an NPM explicitly on their website, while two others have not done so.[190]

The NPMs have not developed specific NPM working methods. Nor do they carry out specific NPM-visits to places of detention. One interviewee explained: 'during our visits the inspection does not wear a specific NPM-hat'. As such it is not possible to assess if and if so with which frequency NPM visits take place.

The SPT interviewees are under the impression that the Dutch NPMs perceive their new role as 'business as usual'. The SPT members, as well as the Dutch National Ombudsman, consider that this is not necessarily a bad thing. However, it does require that the existing methods are effective.[191] Furthermore SPT members observe that the approach in the Netherlands is usually reactive rather than proactive.[192]

Collaboration

The first NPM annual report indicates that the designation of the various NPMs has been a first important step towards collaboration as a multiple NPM. The various NPMs do not only visit different types of places of detention; the legal frameworks under which they operate also differ, as well as their disciplinary backgrounds and contexts. The mix of different organizations that must collaborate with one another for the first time is seen as an important new challenge.[193]

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[188] 'Key featues' of the NPMs, according to SPT.

[189] Conclusion based on the interviews with the NPMs.

[190] IVenJ, RSJ and CITT; on the other hand IGZ and IJZ do not provide information on their NPM tasks on their website, nor on their long-term policy statements.

[191] Interview with members of the SPT and with the National Ombudsman of the Netherlands.

[192] Interview with members of the SPT, 20 June 2013..

[193] First Netherlands NPM annual report.

An advantage of the designation of existing organizations as NPMs is that there is a reliance on existing knowledge, experience and networks. A positive point is that the OPCAT framework has intensified the existing collaboration between the various NPMs. According to the National Ombudsman of the Netherlands the NPMs are making a sincere effort to create coherence among the various organizations. They take an interest in the experiences of their sister NPMs and they seek to embed these experiences in their own fields of operation. [194]

However, the National Ombudsman of the Netherlands also sees a disadvantage in the creation of a system of multiple NPMs: someone has to take the lead and this leadership has to be recognized by the other organizations. However several interviewees from the separate NPMs expressed satisfaction over the coordination by IVenJ. The NPMs get together a few times a year so as to get more insight into each others activities. In 2012 IVenJ organized an international conference about the synergy between international, European and national supervision.[195]

Which standards do the NPMs use?

According to OPCAT the NPMs should create consistency when it comes to using the international ill-treatment standards: the various organizations should use the existing standards in a similar fashion. The Netherlands Institute for Human Rights observes that the standards are indeed being used, however that this is not always made explicit. The Institute is of the opinion that the NPMs should use the international standards as an addition to their existing framework.[196]

IVenJ is used to using international standards including, for example, the European Prison Rules and the ECPT standards. These standards are being used as assessment frameworks. However not all organizations operate in this way, also because their role as an NPM only constitutes a small element of their overall mandate. Hence some NPMs (IGZ and RSJ) indicate that they mostly use national standards, which according to these NPMs reflect the international standards.[197] IVeJ is of the opinion that awareness should be created about the use of international standards.[198]

[194] Interview with the National Ombudsman of the Netherlands.

[195] International conference SPT-CPT-NPM, 1st of June 2012 Penitentiary institution 'Nieuwersluis', the Netherlands, available at http://www.ivenj.nl/onderwerpen/nationaal_preventiemechanisme_%28NPM%29/internationale_conferentie/

[196] The Netherlands Institute for Human Rights, *Submission to the UN Committee against Torture on the Examination of the sixth Periodic Report of the Netherlands in May 2013*, p. 12.

[197] Interview with IGZ 4 April 2013; Interview with RSJ, 23 April 2013.

[198] Interview with IVeJ, 26 March 2013.

In this respect it is interesting to note that the NPMs in New Zealand have developed their own NPM standards that are based on international human rights norms.[199] In addition to these self-set standards, the NPMs in New Zealand look at the standards provided by the United Nations Training Manual on Human Rights Monitoring.[200]

Prevention

According to the SPT the NPMs should act proactively rather than as a mere reactive complaint mechanism. Visits should be conducted with the aim of strengthening the protection against ill-treatment of persons deprived of their liberty; and the NPMs should make recommendations with the aim of improving the circumstances of these persons. In the light of OPCAT, supervision merely based on risk-indicators does not suffice. [201]

According to the SPT, when it comes to prevention the main concern is protecting human dignity. OPCAT requires the establishment of a constructive dialogue so as to improve the circumstances of persons deprived of their liberty. Among other factors, the working conditions of (healthcare) personnel may influence the way in which persons deprived of their liberty are being treated. It is essential that the person who conducts the visits has the necessary experience and sensitivity to the various factors that may trigger the ill-treatment of persons deprived of their liberty.[202] It should be taken into account that preventive visits are both costly and time-consuming: by way of an example the APT referred to a visit of the French NPM to a detention center, which took two weeks.[203]

The National Ombudsman of the Netherlands also emphasizes the importance of prevention. NPMs should try to find out how they can effectively influence the Government in terms of what is important when it comes to prevention.[204]

6.2.2 Functioning with respect to 'healthcare settings'

What are the challenges when it comes to conducting visits to healthcare settings where persons have been deprived of their liberty?

Standards

[199] To be downloaded via http://www.hrc.co.nz/human-rights-environment/monitoring-places-of-detention/monitoring-standards ; accessed July 2013.

[200] OHCHR, Training Manual on Human Rights Monitoring, Professional Training Services no 7 (OHCHR, 2001), pp. 87-95.

[201] Interview with the SPT, 20 June 2013.

[202] Interview with APT, 20 June 2013.

[203] Interview with APT, 20 June 2013.

[204] Interview with representative of the National Ombudsman, 23 April 2013.

When it comes to care for psychiatric persons and mentally disabled persons there is a lack of international standards comparable to the European prison rules. This creates difficulties when it comes to the monitoring of these bodies.[205]

Sensitivity to inhuman or degrading treatment ('ill-treatment')

Several of our interviewees have raised the question of how to interpret the term 'inhuman'. According to the interviewees it requires some nuancing as it contains a very subjective element: what is considered as 'inhuman' by one patient does not have to be experienced in that same way by another. Several examples of this nuancing were provided during the interviews. The Health Care Inspectorate (IGZ) gave as an example that some patients prefer to stay in a separate unit rather than in modern IC-type units.[206] Sometimes girls prefer to stay in a solitary cell as there they feel safe and free from incentives and they cannot injure themselves. Beweging 3.0 gives the example of your persons with dementia: they find it very difficult to find rest and calmness, and as such a belt can be beneficial, as it forces the calmness upon them.[207]

SPT indicates that when it comes to ill-treatment in healthcare settings, the main concern is the psychological attitude rather than the physical situation: 'treat them as human beings, not as patients'.[208]

According to the National Ombudsman of the Netherlands ill-treatment should always be considered in the context of the situation at hand. The treatment of patients is always a matter of weighing various alternatives; and in order to get a proper image of what is really going on the concrete settings need to be assessed.[209]

Pharos indicates that a crucial issue is how healthcare providers act when they face a setting that may be characterized as 'inhuman'.[210] Beweging 3.0 adds that healthcare providers are in good a position to assess what is 'inhuman' for the individual patient.[211] Similarly, the SPT is of the opinion that the attitude of health care professionals is of great importance. It is in this respect important that health care specialists realize that their actions are being monitored and assessed. Ultimately, it is the weighing of interests by the health care provider that counts.

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[205] Elina Steinerte, Rachel Murray & Judy Laing, ´Monitoring those deprived of their liberty in psychiatric and social care insitutiions and national practice in the UK´, *The International Journal of Human Rights*, Vol. 16, No. 6, August 2012, p. 865 - 882.

[206] Interview with IGZ, 4 April 2013.

[207] Interview with Beweging 3.0, 11 April 2013.

[208] Interview with SPT member, 20 April 2013.

[209] Interview with representative of National Ombudsman.

[210] Interview with Pharos, 10 March 2013.

[211] Interview with Beweging 3.0, 11 April 2013.

Which important shortcomings in healthcare settings have come to light through the work of the NPMs?

Have the NPMs covered these shortcomings sufficiently?

All the so-called 'risk factors' mentioned in chapter 4 receive the attention of the Dutch supervisory bodies which have been designated as NPMs. However, it is not possible to establish which shortcomings in healthcare settings have come to light through the specific work of these bodies as NPMs, as these bodies do not conduct specific NPM visits. As a result it is not possible to assess whether these NPMs have covered these shortcomings sufficiently.

IGZ (Dutch Health Care Inspectorate)

IGZ is the most important NPM when it comes to conducting visits to healthcare institutions. Its overall mandate is to promote public heath by overseeing the quality of healthcare services.[212] Recently, IGZ has been criticized for failing to take the complaints of patients seriously and for responding too slowly to medical malpractices.[213] In a recent report, the National Ombudsman of the Netherlands has formulated eight points for improvement by IGZ. [214] The Minister of Health, Welfare and Sport, in response to several critical reports,[215] has concluded that IGZ does not adequately conduct its supervisory role. IGZ should be a body for patients and in the exercise of this task it should have more consideration for the experiences of patients.[216] A special 'care window' has been established that functions as an advisory and complaint mechanism for patients.[217] While these activities are worthwhile in themselves, for the purposes of our report it is important to establish that none of the above-mentioned reports mentions IGZ's role as an NPM. We conclude that IGZ's role as an NPM does not have priority, nor with IGZ itself, the Government, or other institutions or researchers. This suggests that some of the designated NPMs do not seem to be aware of their important role as part of an international framework for preventing acts of torture or IDTs. It is equally doubtful that the relevant stakeholders in the health care settings, such as health care institutions, care homes for the elderly, care givers, and those responsible for correctional institutions, are also aware of the important role of the designated NPMs in preventing torture and IDT in health care settings.

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[212] IGZ; for information in English see http://www.igz.nl/english/ , last visited 16 July 2013.

[213] FAG Hout, ED Nienhuis, PBM Robben BJM Freriks and J Leegemaate, 'Supervision by the Dutch Health Care Inspectorate', *European Journal of Health Law*, 17 (2010), pp. 347-360.

[214] National Ombudsman, 'Geen gehoor bij de IGZ. Signalen over de Inspectie voor de Gezondheidszorg' [no reply at the IGZ], 2 April 2012, 2012/051.

[215] *Inter alia* Doorpakken! Organisatieonderzoek naar de Inspectie voor de Gezondheidszorg [Get on with it! Organizational research into the functioning of IGZ], Koos van der Steenhoven, 19 November 2011.

[216] Letter from the Minister of Health, Welfare and Sport, 15 February 2013, *Kamerstukken* 33 149, nr. 19.

[217] Up to this point, only for a limited amount of branches in the health sector (specialist care, hospital care for the elderly, and mental healthcare).

More specifically, when it comes to persons deprived of their liberty in healthcare institutions, it is essential that there is structural supervision over their well-being. For this group it does not suffice that there is a complaint mechanism. However, IGZ only takes action in case of a calamity or a structural shortcoming in the quality of care.

Unannounced visits

Furthermore, the question arises as to whether IGZ's supervisory role complies with the regular and preventive character of supervision as required by OPCAT. The National Ombudsman of the Netherlands is concerned about the limited amount of unannounced visits conducted by IGZ. The National Ombudsman has the impression that the frequency of such visits is limited compared to some other countries.[218] Research carried out by Sorgdrager indicates that IGZ is reluctant when it comes to unannounced visits. Sordrager advises to increase the amount of visits and to monitor progress.[219]

6.3 How can the functioning of the NPMs be improved?

The effective operation of the NPM is a continuing obligation. The effectiveness of the NPM should be subject to regular appraisal by both the State and the NPM itself, taking into account the views of the SPT, with a view to its being reinforced and strengthened as and when necessary.[220]

Creating awareness and visibility

According to IVenJ, the added value of OPCAT lies especially with the creation of awareness about the international context of the work of the national supervisory bodies.[221] While this awareness can still grow, there could also be more awareness about the incidence of inhuman or degrading treatment in healthcare settings.[222]

NPMs should make their activities visible and should develop their own identity as an NPM. According to SPT the NPMs should get together and reflect about their mission and vision in light of OPCAT and the Paris Principles. The NPMs should develop strategies and activities. According to an interviewee 'the annual report to the SPT is a nice cherry on the cake, however the effect of the work of the NPMs should be more visible in the Netherlands'.[223]

Collaboration

The interviewees agree unanimously that collaborating more closely is a challenge. While there is a certain amount of collaboration, it could be intensified, which according to RSJ

[218] Interview with representative of National Ombudsman.

[219] W. Sordrager: 'Van incident naar effectief toezicht' [From incident to effective supervision], 19 November 2012.

[220] SPT Guidelines, para 15.

[221] Interview with representative IVenJ, 26 March 2013.

[222] Interview with representative IVenJ, 26 March 2013.

[223] Interview with representative of RSJ, 23 April 2013.

requires time and efforts.[224] According to the Netherlands Institute for Human Rights, the tasks should be fulfilled collectively.[225] According to Murray, for this the Netherlands can learn from other multiple NPMs, including New Zealand and the United Kingdom. In the United Kingdom, where initially there was little collaboration between the considerable number of bodies which comprise the NPM, they increasingly work collectively on a range of issues.[226] The APT suggests that NPMs could exchange employees.[227]

6.4 The Kingdom outside of Europe (BES-islands)

In 2010 the Kingdom of the Netherlands underwent a constitutional reform with respect to Kingdom's Antilles overseas territories. The islands of Curaçao and St. Maarten became autonomous countries within the Kingdom joining the island of Aruba, whereas the smaller islands of Bonaire, St. Eustatius and Saba (the BES Islands) became special municipalities of the country of the Netherlands. This had an impact on the debate surrounding the ratification of the OPCAT by the Netherlands. Initially the ratification of the Optional Protocol would apply to the Netherlands Antilles. Due to the political sensibilities of the constitutional reform, however, it was later decided that the countries of Aruba, Curaçao and St. Maarten could on their own later decide whether they would accede to the Protocol. Thus, the Netherlands ratified the OPCAT only for the parts of the Kingdom in Europe. This leaves certain ambiguity with respect to the question of whether the BES Islands are covered by the OPCAT or not. The IVeJ seems to suggest in its first NPM annual report that they assist in the coverage of these special municipalities together with some local authorities. In its 2012 general national report to the Dutch House of Representatives, the IVeJ acknowledges that it has some monitoring tasks with respect to its law enforcement and crisis and disaster management mandates in the BES islands on the basis of the BES Security Law (Veiligheidswet BES) and the Law on the Council for Law Enforcement (Rijkswet Raad voor de rechtshandhaving).[260] It is not clear, however, from the report how the IVeJ's NPM tasks are related its other mandates. With respect to Aruba, Curaçao and St. Maarten there is currently no NPM coverage under the OPCAT. Although there seems to be local supervisory committees of prisons, it is not entirely clear whether these bodies fulfill the requirements of independence and autonomy. Persons deprived of their liberty on these islands therefore do not benefit from the preventive effect of independent bodies (NPMs or the SPT).[261]

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[224] Interview with representative RSJ, 23 April 2013.

[225] Netherlands Institute for Human Rights, 'The Netherlands Institute for Human Rights Submission to the UN Committee against Torture on the Examination of the sixth Periodic Report of The Netherlands in May 2013'.

[226] Interview with Professor Rachel Murray, University of Bristol, 27 February 2013.

[227] Interview with APT.

[260] Jaarbericht 2012 Inspectie Veiligheid en Justitie (Annual report 2012, IveJ), p. 39 available at http://www.ivenj.nl/actueel/inspectiejaarbericht/jaarbericht-ivenj-2012.aspx?cp=131&cs=64448

[261] Commentary on the sixth periodic report submitted by the Kingdom of the Netherlands on the implementation of the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT/C/NLD/Q/6), Nederlands Juristen Comité voor de Mensenrechten (NJCM), May 2013.

At this moment it is unclear whether or not OPCAT applies to the BES islands. As these islands are a part of the country of the Netherlands, it would be reasonable to conclude that OPCAT would be applicable to those islands. However, no reference to the islands was made when appointing the NPMs, nor does the first annual report of the NPM contain any indications as to the work of the Dutch NPMs on the islands. The islands have their own inspectorate, the Law Enforcement Council, but the relationship between this Council and the Dutch NPMs with respect to its OPCAT tasks is not clear. In its concluding observations to the Netherlands' combined fifth and sixth periodic report under the Convention against Torture, the Committee Against Torture expressed its concern for this lack of clarity, and recommended the Netherlands to "[e]xplain, in its next periodic report, what progress has been made to accept and apply the Optional Protocol to the Caribbean part of its territory and the autonomous islands in order to establish the NPMs tailored for the needs of the islands and allow for the visits by the Subcommittee on Prevention of Torture."[262]

7 Conclusions and recommendations

The conclusions and recommendations to this research have been drafted against in light of our brief inventory of existing findings about risk factors of persons deprived of their liberty in (health care) institutions. The most pressing concerns are (sexual) abuse and the (unnecessary or irregular) use of tools and measures restricting the freedom of individuals. Also a lack of time and money affect the possibility of offering humane care. Of great concern are the circumstances under which aliens are being detained. It does not appear that the establishment of NPMs has improved the situation of persons deprived of their liberty in a health care institution.

In our assessment of the functioning of the Dutch NPMs, we have taken into account the fact they have only been established one-and-a-half year ago. Our research question was as follows:

How do the Dutch NPMs carry out their supervisory role with respect to relevant healthcare institutions?

To address this question, the OPCAT and SPT conditions for NPMs have been scrutinized. It appears that the Dutch NPMs do not (yet) meet these conditions. We have the following (disjointed) observations:

In terms of *mandate* the NPMs appear to meet the basic requirements set by OPCAT and the SPT. However a point of concern is the (presumed) independence of some of the NPMs. While the actual independence of these bodies seems guaranteed, these bodies may not be perceived as being functionally independent (and some of them are not legally/formally independent), especially to foreign institutions and persons.

[262] Concluding observations on the combined fifth and sixth periodic reports of the Netherlands, adopted by the Committee at its fiftieth session (6-31 May 2013), Committee Against Torture, UN Doc. CAT/C/NLD/CO/5-6, 20 June 2013, para. 28.

It has also become clear that the qualification as an NPM has not led to an *adjustment* of the organization, for most NPMs. Two NPMs do not mention their qualification as an NPM on their websites, nor in their long-term vision statements or in their annual report.

Furthermore, as to the *methods and the frequency of the visits* by the NPMs to healthcare institutions, it has not been possible to assess these, as specific 'NPM visits' do not yet take place. However it is clear that little use is being made of the possibility of *unannounced visits*.

There is a *lack of common standards*. Not all NPMs work explicitly with the international standards. The NPMs depart from the assumption that national legislation covers the international standards. This does not imply that the OPCAT objectives are not being met, however it is not visible. Standards should be mentioned and addressed when used and where necessary new standards need to be developed.

The *annual reports* of the NPMs currently do not adequately reflect the activities of the NPMs. Ideally, they should embrace more than a mere description of activities of each separate NPM. The APT suggests that thematic annual reports could be made, for example focusing on healthcare.

Future perspectives

The Dutch NPMs are still in their infancy. The development towards an NPM is a step-by-step process. Over the course of the coming years more steps have to be taken for the NPMs to comply fully with the OPCAT requirements.

During our interviews it has become clear that the NPMs take a positive and proactive approach towards their designated tasks. They could be supported more by the Government, both financially as well as with appropriate training. The NPMs could take as an example other existing NPM-mechanisms that have existed over a longer period of time, such as the British and New Zealand mechanisms. The recommendations, advice and other information provided by the SPT and APT can also be of support.

Prevention is an ongoing process and requires a proactive, holistic approach. The NPMs are required to follow this approach. Mere reactive supervision does not suffice. According to the SPT the NPMs should convene and reflect on their mission and vision in light of OPCAT and the Paris Principles. Methodologies and activities should be developed. They should look at what they are required to do and act accordingly. They should also address problems at a higher level.[263]

Furthermore, it is important to pay attention to human rights concerns during the training of health professionals. Health professionals should be trained to recognize and signal situations of ill-treatment.

To quote the National Ombudsman of the Netherlands: "It is about reflecting on how the situation can be improved. You can start with big ideas for which there is no money but those are usually not very effective. It is better to go and talk to people to find out how things can be improved in a given situation. For example in a report about alien detention it is about

[263] Based on an interview with a Member of the SPT.

small things that can make life more humane such as offering meaningful activities. Visits can also be of vital importance to persons deprived of their liberty. By improving a few circumstances out of many the other circumstances will also become easier to bear. The challenge lies in finding those elements that authorities at all levels recognize as something that can be addressed en that persons responsible for taking the action can also relate to."[264]

General Recommendations

To the Government of the Netherlands, and the Minister of Justice and Security: One or multiple NPMs?

Clarity needs to be created surrounding the question of whether in the Netherlands there is one NPM or whether there are several NPMs.

To the Government of the Netherlands: Independence

The mandate and competences of the NPMs should be laid down in legislation, in conformity with the SPT Guidelines. This will enhance the presumed independence of the NPMs.

To the Government of the Netherlands: Financial independence

There has to be sufficient budget for the NPMs. The NPMs can ask for the support of the SPT when it comes to addressing the Dutch Government's obligations in this regard.

To the Netherlands NPMs: International standards

There is a need for more awareness about the international standards both with regards to the Dutch NPMs and with society at large.

To the Netherlands NPMs: OPCAT role and information on NPMs' websites

Organizations designated as NPMs should endeavor to increase the awareness of their tasks in preventing torture and IDT, in particular with respect to health care settings, within their individual internal organization and externally to the relevant stakeholders in the health care sector; they should also mention information about their qualification as an NPM on their websites.

To the Government of the Netherlands: BES-islands

Clarity has to be created concerning the applicability of OPCAT on the BES-islands.

To the Government of the Netherlands, the House of Representatives and all stakeholders including NPMs, associates and civil society organizations: Evaluation

SPT recommends the evaluation of the functioning of the NPMs after two years.

[264] Interview with the National Ombudsman of the Netherlands.

List of abbreviations

APT:	Association for the Prevention of Torture
Wet BIG:	Wet Beroepen Individuele Gezondheidszorg Healthcare Professionals Act]
Wet Bopz:	Wet bijzondere opnemingen in psychiatrische ziekenhuizen [Psychiatric Hospitals Compulsory Admissions Act]
CAT:	Committee Against Torture
CITT:	Supervisory Commission on Repatriation
CPT	European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment
CRC:	Convention on the Rights of the Child
DJI:	Custodial Institutions Agency
ECHR:	European Convention on Human Rights and Fundamental Freedoms (Council of Europe)
IFFHRO:	International Foundation of Health and Human Rights Organizations
IJZ:	Youth Care Inspection
JJI:	Correctional Institutions for Juvenile Offenders Sector JZ+: Closed Youth Care
IVenJ:	Inspectorate of Security and Justice
KMar:	Royal Netherlands Marechaussee
NJCM:	Dutch Society of Human Rights Jurists (Dutch section ICJ)
OPCAT:	Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
OSF:	Open Society Foundations
PPC:	Forensic Psychiatric Centers
RSJ:	Council for the Administration of Criminal Justice and Protection of Juveniles
SPT:	Subcommittee on the Prevention of Torture
STJ:	Collaborative Youth Supervision
UNCAT	UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
VWS:	Ministry of Health, Welfare and Sport of the Netherlands

Wob: Freedom of information Act

Annex 1 List of interviewees

Association for the Prevention of Torture: Barbara Bernath, Chief of Operations

College voor de Rechten van de Mens: Ms A. Van Eijndhoven, LLM and Ms J. Naber, LLM

Inspectie Veiligheid en Justitie: Ms F.B.A.M. Hofstee-van der Meulen, senior inspector and NPM-coordinator

Inspectie voor de Gezondheidszorg, Ms M.A. Schippers, LLM

Inspectie Jeugdzorg: Mr I.S.I. Levie, LLM, legal officer and Mr W. Weltevrede, senior inspector

National ombudsman: Ms A. Stehouwer, LLM, substitute ombudsman en Mr M. Ramlal, LLM, PhD, policy advisor

Raad voor Strafrechtstoepassing en Jeugdbescherming: Ms S. Jousma, LLM, coordinating secretary legal decision-making en Mr A.J. van Bommel, advisor

Pharos: Dr E. Bloemen, consultant and advisor

Zorgorganisatie Beweging 3.0 (regio Eemland): Dr. G. Antonides, nursing home consultant

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